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ABSTRACT

The monograph addresses the place of special education in the continuum of rehabilitation services with particular emphasis on special education in Denmark and the United States. New Danish laws about services for handicapped people and their implications for such aspects as normalization, decentralization, and integration are reviewed and evaluated. Planning procedures for Danish special education are noted, as are the status of preschool special education and the types of services available to parents of handicapped children. Aspects of special education school services, such as reorganization, referral, and teacher education are covered. A section on special education for adults focuses on such matters as continued education, occupational preparedness, and recreational programs. A checklist for an overall rehabilitation program is provided. The monograph concludes with five commentaries: "Special Education and Vocational Rehabilitation" (D. Brolin); "Special Education in Denmark and the United States" (H. Jacoby-Blanchard); "Implementing P.L. 94-142" (P. Dvonch); "Comprehensive Programming through Local Communities" (R. Heber); and "The Interface of Special Education and Rehabilitation Services" (R. Stodden). Also included is a summary of recommendations from a 1980 conference in Washington, D.C. on "The Interface of Special Education and Rehabilitation: A Continuum of Commitment." (CL)

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MONOGRAPH NUMBER SEVEN

The Role of Special Education in an Overall Rehabilitation Program

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CONTENTS

INTRODUCTION 1

THE GOALS OF SPECIAL EDUCATION IN DENMARK 2

THE NEW DANISH LAWS 6
- Normalization
- Decentralization
- Decategorization
- Integration

NEW AREAS COVERED BY LAW 10
- Pre-school children
- Special education for adults

PLANNING 12

SPECIAL EDUCATION AS PART OF OVERALL REHABILITATION 13
- Special education services for young children
- Preventive programs
- Early identification programs
- Pre-school programs
- Special problems for parents of a handicapped child
- Respite care
- Programs for parents
- The special education consultant

SPECIAL EDUCATION FOR SCHOOLAGE CHILDREN 24
- Organization of special education
- Referral to special education
- Professional assistance to local school districts
- Centers providing special technical and education aids
- After-school programs
- Training the special educator
- Integrating severely handicapped children

SPECIAL EDUCATION FOR ADULTS 36
Young adults
Continued education
Daily environment
Occupational preparedness
Recreational programs
Involvement in a work situation

CONCLUSIONS 44

CHECKLIST FOR AN OVERALL REHABILITATION PROGRAM 46

REFERENCES 49
Additional related literature

U.S. COMMENTARIES 53
THE AMERICAN VIEWPOINT
Special Education and Vocational Rehabilitation—Donn E. Brolin
Special Education in Denmark and the United States—Helen Jacoby-Blanchard
Implementing P.L. 94-142—Patricia Dvonch
Comprehensive Programming through Local Communities—Rick Heber
The Interface of Special Education and Rehabilitation Services—Robert A. Stodden

PREFACE

THE INTERNATIONAL EXCHANGE OF INFORMATION IN REHABILITATION

In order to put this particular piece of writing into perspective, it is important first to cite the legislation to which the International Exchange of Information in Rehabilitation is responsive:

REHABILITATION ACT 1973

REHABILITATION, COMPREHENSIVE SERVICES, AND DEVELOPMENTAL DISABILITIES AMENDMENTS OF 1978
RESEARCH

Section 202 (b) 5.

Conduct of a program for international rehabilitation research, demonstration, and training for the purpose of developing new knowledge and methods in the rehabilitation of handicapped individuals in the United States, cooperating with and assisting in developing and sharing information found useful in other nations in the rehabilitation of handicapped individuals, and initiating a program to exchange experts and technical assistance in the field of rehabilitation of handicapped individuals with other nations as a means of increasing the levels of skill of rehabilitation personnel.

To develop this project and implement the law, a series of considerations were addressed by the World Rehabilitation Fund. These considerations took into account the following:

- What are the knowledge and method gaps which would satisfy the information needs of the rehabilitation system in the United States?
- In what form could information developed in other countries be presented?
- What are the key transmission points/target audiences for sharing knowledge in the U.S. rehabilitation community?
- What foreign resources can be identified to develop and share the information?
- How can one evaluate the effectiveness of the program?
- What steps could be taken to build on utilization of the materials?

The International Exchange of Information in Rehabilitation project is designed to facilitate the sharing of rehabilitation information transnationally by commissioning a series of brief monographs by foreign experts on topics which reflect knowledge gaps in rehabilitation in the United States. The design for the project emerged as the result of determining that a need existed for information to be made available transnationally to targeted groups of U.S. rehabilitation personnel at a length which would make information accessible and readable while at the same time satisfying curiosity about the particular subject.

In May 1978 a Transnational Conference was held by World Rehabilitation Fund to which four foreign rehabilitation experts (generalists) and eight U.S. "centers of influence" in rehabilitation were invited, including representatives from the State Vocational Rehabilitation system, the American Coalition of Citizens with Disabilities, a Research and Training Center, the National Rehabilitation Association, Rehabilitation Counselor Education, and the Rehabilitation Services Administration (now the National Institute of Handicapped Research), as well as the World Rehabilitation Fund's Officers and Consultants.

The primary goals (as they related to the International Exchange of Information) of this meeting of the Advisory Council were to:

- Decide on the knowledge gaps in rehabilitation in the U.S. to which this project would be responsive.
- Obtain nominations from the foreign advisors present for potential monograph authors (individuals from their countries who could expertly address the topics).
- Determine the target audiences for the monographs.
- Develop the evaluation component of the program.

Final selection of five monograph authors for this Project Year was made by World Rehabilitation Fund staff and consultants and these authors were then commissioned to prepare monographs. Initial first drafts were submitted for U.S. and foreign peer review. The resulting reviews were then returned to the authors, who had the opportunity to make use of any comments, suggestions or criticisms in the preparation of the final draft.

Also, where utilization meetings were held (the project design calls for the holding of conferences to promote research utilization and knowledge transfer on three of the five monographs), authors, in some cases, have made use of the interaction at these meetings to make final alterations or additions to their material.

The World Rehabilitation Fund International Exchange of Information in Rehabilitation has elected to publish as a companion to the monographs commentaries and remarks of participants in the utilization meetings in order to put the foreign authors' material into a U.S. context.

The World Rehabilitation Fund, Inc. is indeed pleased to be able to present this Monograph Series to the United States rehabilitation community with the hope that the monographs will help to promote the continuing exchange of information transnationally toward the ultimate goal of enhancing the quality of life for the disabled in the United States and all over the world.

It must be said, however, that the World Rehabilitation Fund, Inc. took the philosophical position of allowing complete freedom in the preparation of these monographs. Therefore, the views expressed (and the knowledge and information conveyed) are those of the author, the sources the author has selected, and the national socio-economic context from which the material emerges.

Howard A. Rusk, President
World Rehabilitation Fund, Inc.

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The World Rehabilitation Fund, Inc. wishes to thank Helen Jacoby-Blanchard, Ph.D., Special Education Consultant, Memphis, Tennessee, and Lenore Ringler, Ph.D., Department of Special Education, New York University, for providing expert peer review on the initial drafts of the monograph. We also wish to thank those individuals who contributed the commentary which accompanies Dr. Dyssegaard's work.

Donald Linkowski, Ph.D., Robert Ianacone, Ph.D., and Andrea Farbman Morris of George Washington University contributed their time and efforts in cosponsoring a conference with World Rehabilitation Fund, Inc., "The Interface of Special Education and Rehabilitation: A Continuum of Commitment," at which Dr. Dyssegaard was a keynote speaker and the monograph served as a stimulus for discussion and action. The commentaries by Robert Stodden, Ph.D., and Donn Brolin, Ph.D., which appear here are based on papers which they presented at that conference.

We are very appreciative of the editorial services of Viola Roth of William H. White Associates, New York.

George Engstrom, the Project Officer for the International Exchange of Information in Rehabilitation, has been consistently supportive of the project, for which we are very grateful.

Finally, the World Rehabilitation Fund, Inc., International Exchange of Information in Rehabilitation would like to acknowledge the considerable effort and interest which Dr. Birgit Dyssegaard gave to the preparation of her material.

INTRODUCTION

The long-term goal set for special education often does not extend beyond a single school year, with little discussion of pre- or post-school experience. At most, there is some concern voiced for the child's future as he or she becomes older. But this attitude should change in future programs. Special education should not be considered a goal in itself, separated from the overall goal of rehabilitation. There is, in fact, a strong need to coordinate special education and rehabilitation services.

This monograph examines the role of special education in just such an overall rehabilitation program, drawing on the author's experience with both the Danish and American systems for providing aid for the handicapped. New Danish laws about services for persons with handicaps are described and evaluated. Although there is as yet no comprehensive rehabilitation system in operation in either country, overall planning for the special education of severely handicapped children and adults has already begun. The analysis of programs and the suggestions presented in this monograph are based partly on the preliminary steps being taken in the County of Copenhagen to develop a comprehensive special education program for the 1980s.

THE GOALS OF SPECIAL EDUCATION IN DENMARK

Special education for schoolage children is particularly well organized in Denmark. Most children with special needs are identified early and have many services available to them. In the United States, Public Law 94-142 guarantees the right of free and appropriate education to all handicapped children. The laws in both countries have the same intent: To develop a system whereby children with special needs are identified and offered special services, including special education, according to need, as part of an overall rehabilitation program. Efforts so far have been largely directed to organizing the system for delivering this aid, but there are equally important questions that must now be addressed. These concern the quality and the goals of special education, what the system should offer, and how it should go about providing these services.

In Denmark, the goal of special education is identified with that of regular education. The same law governs both, and the goals of both are formulated in the same terms.

> Paragraph 2 of the Danish law on public education states:
> The aim of public education is for the schools, together with the parents, to provide students with the opportunity to acquire knowledge, skills, work habits and means of expression that contribute to the overall development of the individual student.
>
> Section 2 states:
> The public school must direct all its activities to creating the kind of environment within which the student's desire to learn will be encouraged, and his or her creativity, decision-making capability and independent judgment will develop.
>
> Section 3 states:
> The public school prepares the student for participating in and contributing to a democratic society, and for sharing in the responsibility for solving common problems. The education program and the daily activity of the school must therefore be built on principles of democracy and intellectual liberty.[1]

The Danish public school system has been organized to fulfill these goals. Because it is believed that children can best develop when they are placed in heterogeneous groups, they

are not separated by either formal or informal evaluation. Thus children who start kindergarten or first grade together remain together with the same teachers (one for each subject) at least through grade seven and often through grade nine.

There has been much discussion among Danish educators about methods for creating the most meaningful educational environment for all children in these heterogeneous groups. For the last decade or more, emphasis has been placed on social development through group discussions, participation in decision-making about school programs, and joint projects. Today, however, both parents and older students are insisting that the emphasis return to traditional education, particularly academic training in basic subjects. This trend is also evident in other countries faced with a less prosperous economic outlook than that of the 1960s, including increased unemployment and a decline of available resources.

The Danish laws concerning education for the severely handicapped now going into effect were, however, drafted in the more prosperous years of the 1960s. They must now be implemented in a more economically constrained decade. At the same time, public schools, particularly in suburban areas, are faced with problems of minority students that have previously been all but nonexistent in the Danish school system. Children of immigrants with different languages, traditions, and values have entered public schools in large numbers. Much effort has gone into developing a proper educational program for these students, including bilingual instruction and special orientation programs for newly arrived children and their parents. In spite of these efforts, many problems remain in this area.

Integration ("mainstreaming")

The trend during the last decade or so has been to keep children with special needs in their regular classes, ensuring that these children will remain with their group at least seven years. Previously, most special education was offered in small groups outside the regular classroom, or in special classes with restricted enrollment, taught by teachers trained in special education.

In some progressive school districts, all or most special classes have been discontinued, and special education has been offered in the child's regular classroom by an assistant teacher or supplementary special education was offered in a separate

room (resource room). Such school districts did not cut back their budgets for special education, but rather spent more per student than districts that maintained special classes.

This trend has been called "integration" in Denmark and "mainstreaming" in the United States. The concept has been the subject of much debate in recent years in Denmark, particularly in relation to new laws that require that even severely handicapped children be taught according to the same principles that govern all public education; that is, their education may no longer be supplied by separate state institutions. The new laws requiring integration do not, however, demand that every child be taught in a regular classroom. The laws are intended to enhance the possibility of regular classroom instruction for even severely handicapped children, if the child's total needs are best met through such a program. Individual need is the crucial factor, demanding a special education system that offers alternatives and has great flexibility.

The principles set down by the Danish Ministry of Education define the goal of integration of severely handicapped children as a method for permitting these children to become part of the social community, allowing them to share in the benefits of community life, to share in the responsibility for projects and other obligations, and allowing them to be educated to their maximum potential.

Integration is intended to bring the handicapped individual into society so that he or she may share in the process of social maturation, thus enabling the individual to live with and interact with others in the community. The public school environment is often better suited for this social development than is the special school setting, where the child associates exclusively with children who are also handicapped. Integration may also help to remove the barriers between the handicapped and the non-handicapped through a process of mutual education and understanding.

The public school setting may also provide the best opportunity for the handicapped child to derive the most from the education process itself. This, of course, is not necessarily true for all handicapped children. A handicap may be so serious as to prevent the child from benefiting from a normal classroom setting, and establishing social relations with other children may be so difficult that it is felt as a strain. Such pedagogic, social,

and emotional considerations may demand that the effort to integrate some students be abandoned.

The Danish Ministry of Education offers some guidelines on integration and the handicapped child's development:

> In relation to the question of the social development of children with severe physical or mental handicaps, it should be remembered that those children also need to be together with other children with similar handicaps. It is not always a question of whether or not to integrate. It is necessary to have an interchange between a regular school setting and a setting wherein the child is with others who have the same or similar problems. This could also have the practical effect of teaching some skills that cannot be taught in the regular public school setting and also help the handicapped individual to develop a personal identity. In many cases, therefore, integration has to be combined with segregation.

Also included is a passage on cooperation and sharing of expertise between special education and other teachers.

This attempt to put forth a general philosophy applicable to individual circumstances clearly demonstrates the problems and dilemmas associated with mainstreaming, integration, and integrating. It also demonstrates how changes in laws and regulations are often more influenced by trends and fads in education theory than by objective evaluation of experiences in the classroom and detailed research into education practices.

The new Danish laws, however, can be regarded as the result of a general change in attitude toward the rights of the handicapped, as well as of close observations of special education services over the last decade.

THE NEW DANISH LAWS

Normalization

Changes in the laws pertaining to public education in Denmark were implemented on January 1, 1980. These changes are similar to those enacted in the United States under the Education for All Handicapped Children Act, Public Law 94-142 (1975). The Danish law established that all children, including handicapped children, are entitled by law to a free education. These regulations on special services are the result of a development away from a system in which the handicapped were secured services through a number of separate laws dealing with specific handicaps. Now all citizens have the same rights, regardless of handicap status. Local municipalities must now offer services to any individual in need of them. Local welfare authorities must provide services and aid based on an evaluation of individual and family need. The kind of assistance offered to a family with a handicapped child might include financial aid to permit a parent to remain at home to care for the child; such special equipment as beds, chairs, wheelchairs and bathroom facilities; transportation; financial aid to purchase an automobile if necessary to transport the child; free day care; and summer vacation and recreation programs.

The handicapped are now entitled to the same municipal assistance others receive in finding employment or in unemployment benefits. Counties are required to provide for severely handicapped individuals who must be placed in institutions for long-term or interim care. In Denmark, of course, all citizens are entitled to free medical care, which includes necessary physical therapy for the handicapped.

In line with these guarantees of legal rights, now even the most severely handicapped will be assured their education through the general law on public education, rather than through separate legislation based on the specific type of their handicap.

Decentralization

The previous system of centralization of services for the handicapped in state institutions has now been changed. As a consequence of normalization, municipalities and counties now share the responsibility for providing necessary services for the

handicapped. Counties have taken over former state institutions and must continue services on at least the former level for the next five years. The rationale behind the decentralization process is that local authorities are better able to meet the needs of the handicapped because they are closer to them and their families. Decentralization also offers a more flexible approach to the problems of the handicapped.

According to law, municipalities will continue to be responsible for providing services to all citizens, including special education services. Counties will provide exceptional services for the most severely handicapped, including special education that is beyond the capability of the municipality. The various laws give only a general outline of services that should be made available, but it is left to the local authorities to organize the services according to local need. Funding is provided jointly by municipalities and counties, from monies formerly allotted to state institutions. It is already apparent that the new funding will not be sufficient to meet either the requirements of the law or the expectations of the handicapped, their families, or professional workers in the field. Present economic exigencies in Denmark have kept the increase in total public spending to within one percent of the 1979 budget figure. Improvement of services for the handicapped will have to be funded by reallocating funds from other areas and by better use of available resources.

Whether decentralization will actually improve services depends to a large extent on cooperation among the municipal departments—education, health, and social services—which now share responsibility for the handicapped. The Ministry of Social Affairs formerly had responsibility for executing the laws that covered each defined handicap category. The Ministry has now made plans for the development of services in each county for the period 1980 to 1985. It is hoped that this will allay fears that there will be a decrease in available services, although the Ministry's plan describes only the minimal level of services that must be provided.

The Ministry of Education must approve all county plans for special education to ensure that all laws and regulations are observed. It is expected, however, that development and trends in different areas of the county will vary according to differences in economy, location, and approach. An anticipated problem is the need to achieve cooperation within various departments of

local governments. This cooperation has not been satisfactory in all cases.

Decategorization

Under new Danish law, the needs and desires of the individual with a handicap and his or her family determine the kind of services that are secured. Previously, special diagnosis of the handicapped individual was used to determine the services and the system through which they would be made available. Regulations continue to be based on specific handicapping areas, not merely because of traditional thinking, but mainly for the purpose of providing opportunity for the individual to benefit from the expertise that has developed in relation to such specific handicaps. In line with recent thinking, it is expected that the eight government circulars on special education will soon be combined into one official publication.

Breaking down barriers between formerly isolated institutions which served individuals with specific handicaps should make it easier to coordinate services and expertise. This coordination will be useful from an overall point of view and should also be of practical value to the handicapped child or young person, particularly those who are multihandicapped and thus more likely to benefit from the combined expertise of several "systems." Categorizing or labeling no longer determines the kind of special education a child is offered or entitled to. Because of this it is possible to develop a system wherein educational needs are determined by an evaluation of the child's total situation, including health, overall physical functioning, personality, home environment.

Danish law is not as specific about a written education program (IEP) or parental involvement as United States law. It does, however, specify the establishment of an individual educational and treatment program for all children in special education. This provision, together with yearly reevaluations, guarantees that children do not remain in a program that no longer meets their needs.

Local school districts continue to share responsibility for their children, even the most severely handicapped, in special schools. An official from the school district, often the school psychologist, participates in the reevaluation conference, and

the district must consent to any major change in the child's educational situation. Because municipalities (school districts) must assume part of the cost of both special schools and regular schools with extensive support, the decision to place a handicapped child in either facility should be made on impartial grounds and not out of budgetary consideration. (The district pays a fee to the county for severely handicapped children taught in special schools).

These administrative changes, as proposed in the new laws, will help to foster the concept of the person with a handicap as an individual with special needs—in sum, a person and not merely the representative of a particular kind of handicap. It will take some time to determine if administrators, professional educators, and public officials can actually implement the intention of the new law. At the present time, however, many professionals, parents, and organizations for the handicapped are doubtful if the expertise and experience developed under the old system can be transferred to the new, decentralized system.

Integration

The laws discussed here are the culmination of efforts by progressive educators to integrate or mainstream all handicapped children into the regular school system. But much anxiety has arisen over the possibility that even the most severely handicapped children would be placed in regular classrooms. Teachers imagined their classes flooded with such difficult pupils; on the other hand, parents of handicapped children feared they would be sent away from special schools to regular school, which would not welcome them and would not know how to deal with them. Although these fears did not materialize, many misconceptions still remain, even though most children, even children with handicaps, are in fact already being taught together in the same system and in the same classrooms. Only about one or two percent of pupils, the most severely handicapped children, are in special schools or special education centers. Not one of these changed the educational situation on the day the new laws went into effect. However, a large number of severely handicapped children who were already in local schools have now been provided with extended services and facilities, and more children will no doubt remain within their local districts because of the change in law.

NEW AREAS COVERED BY LAW

The new laws extend the right to special education to two important new groups: children up to age six and individuals past school age.

For the first time, the right to special education and special educational services has been extended to all children with developmental problems. Previously, no such services were available to children with general developmental problems or with less than severe handicaps (various state institutions did, however, offer some services for the severely handicapped). A few school districts had offered some form of special training for preschool children (age range four to six years) with speech or language problems. Although there were programs for identifying children at risk for developing health, emotional, or behavioral problems, few efforts were made to identify children in need of special education, nor was there much experience with young children in special education programs in the school system. The public health nurses who visit all families with infants regularly during the first year of life were instrumental in identifying children at risk. The nurses work with the family doctor and, often, a team of psychologist, social worker, and other "experts" who can be consulted if special problems are encountered.

Today the focus of Danish pre-school programs has changed from concentration on the child's physical well being to equal concern with mental health. Very young children are brought into contact with the same few adults who involve them in group activities, playing, handling various materials, and listening. The traditional age groups are sometimes broken up in day-care programs so that children below the age of twelve join a mixed group where the younger ones have a chance to watch and imitate the older, and the older watch and help the younger. These experiments seem to indicate that mixed age groups are more beneficial to the younger children (below age ten). It has been more difficult to work out an adequate program for children from ten to twelve years of age.

Day-care and nursery school programs stress stimulation of the child's overall physical and intellectual capacities, but without the use of highly structured educational procedures or activities. In Denmark, as a matter of fact, these programs are not part of the educational system but of the social services system. There

has been much discussion among special educators, child psychologists and day-care center and nursery school personnel about the role of the facilities and the contributions they can make in the future. It will be necessary in the coming years to develop a range of special education services for all young children who need them, including early infant stimulation programs. Such preventive programs should be designed to help parents and nursery school teachers in practical as well as psychological ways to care for children with handicaps. These methods should help the child develop to his or her best potential and at the same time prevent the development of more serious functional problems or additional problems.

The new legal provisions for special education for adults is a departure from the Danish principle of normalization of rights. The legislative committee which prepared the laws believed that special education for adults required separate legislation, particularly because there was no existing law for adult education similar to the public law on education for children, and because it was feared that the special education services provided by former state institutions or other organizations might be discontinued. The new law secures the right of handicapped adults to special education and special educational services which may serve to remedy or reduce the effects of the handicap.

Although counties are now responsible for providing needed special education programs, it is still possible for other organizations, volunteer groups, and even educationally qualified private individuals to offer special education for adults, if at least two adults have signed up for the program. The counties must pay the cost of these privately initiated programs. In all cases, special education is free for all participants, and free transportation to participate in the programs is provided when needed. These and other liberal provisions of the law are reflections of the belief that any adult considered to be in need of special education (in the opinion of the individual or a guardian) is entitled to receive it. The law does not specify any formal requirements (for example, evaluations or referrals), but it is doubtful if relevant special education can be obtained, at least in the initial phase of such programs, without some professional evaluation and counseling.

Danish law also contains special provisions giving handicapped young people and adults equal opportunities to obtain leisure-time education.

PLANNING

Each of the fourteen Danish counties is required to prepare comprehensive plans for special education for children up to the age of eighteen and for adults. The Ministry of Education has set guidelines for these plans, but it has left to the counties the determination of allocation of resources, and the evaluation of present and future needs and programs. In order to make optimum use of existing resources, the counties are required to set priorities in terms of the number of programs, geographic placement of facilities, alternative programs, and so forth. The plans, which must be reviewed and reevaluated each year, are to cover a twelve-year period.

The first drafts of the plans were published in March 1980 and sent to all school systems, parents and concerned organizations. In the County of Copenhagen, there were preliminary meetings with each of the eighteen municipalities within the county, in addition to meetings with all groups affected by the law. The contributions of all were taken into consideration when the first draft was made. In addition, the laws and the planning stages were discussed in educational and professional journals and in the general news media.

A second draft of the plan will receive the same widespread discussion before a final draft is sent to the County Council for its approval. The Ministry of Education should approve the final draft before July 1, 1981. Not until that time, however, will the individual county proposals for developing special education services be integrated within the overall planning for the entire nation. This initial stage of planning was particularly difficult because drafts of the plans had to be prepared before the laws were implemented, leaving little opportunity to see and benefit from the experience of a new and all-embracing system in operation.

SPECIAL EDUCATION AS PART OF OVERALL REHABILITATION

Special education services for young children

The first step in a rehabilitation program begins when a child's handicap is identified. In some children, the handicap is obvious from birth; in others, it becomes evident during the first years, and in some it is not recognized until the child meets the first formal requirements of education.

The first professional who has to inform the parents about a child's handicap should be aware of the enormous importance of what is said, how it is said, and what is left unsaid. Particular care must be taken that the professional estimate correctly the extent of the parents' ability to cope with this information. The importance of how they first learned about their child's handicap is stressed repeatedly by parents. As some of the following statements will prove, many parents feel they were poorly served by professionals who understood the situation but could not explain it in a way that would be either helpful or supportive. Parents remember the painful moment when they first had to realize that there was something wrong with their child. In talking about the experience, they frequently return to the same themes: If we had only known. . . . If we had been told about the handicap and what it would mean. . . . Knowing would have made a difference in so many things. . . .

The following comments have been extracted from statements made by parents of a handicapped child, during a study of how parents react to this experience.

> "There have been many doctors, at least six or seven. I have the impression that none of them—even though they all work at the same hospital—knew what the others said or did about our daughter. . . . No one would give us information. Neither the nurse nor the doctor at the hospital would say anything definite. Finally, I looked into the doctor's case book, and we found a nurse who was willing to explain the notes and charts. Parents should always ask to do that. Don't expect the doctors to tell you. *One must ask.*
>
> ". . . But then the doctor came in and told us she was a mongoloid child. I asked him what that was, since I didn't have any idea. He told me she was retarded. Then he left

immediately. He just came in and said, 'Your daughter is mongoloid,' and he left. I think it was the next day that I finally got permission to see her. Because I hadn't really seen her when she was born, I imagined a child without an arm or leg. The doctor explained a little more about Down's syndrome. He was very negative and we imagined worse than it was."*

The study from which these statements are taken was conducted in both Denmark and the United States. Parents in both countries react the same way after the birth of a disabled child—with disappointment, sadness, confusion, even anger and guilt. These emotions are likely to threaten the parents' self-esteem, since children are often seen as reflections of their sense of worth. Danish parents in the study were by and large familiar with and appreciative of the comprehensive social services available to them and their children, particularly free medical care and free home visits from a public health nurse. But in the study some important shortcomings of the welfare system were identified. These can be summarized as follows:

Difficulty in obtaining accurate information about the nature of various handicaps and the services available for dealing with them. Parents felt that many doctors, public health nurses, and social workers lacked sufficient knowledge about handicaps.

Delays in access to important supportive services, particularly early infant programs. Sometimes access was refused or there were no programs available.

Incomplete communication between professionals, particularly medical staff.

Failure of social welfare agencies to take a family's individual needs into consideration.

Even when the social welfare system did function smoothly, the knowledge that these services were available, or even the use of them, did not lessen the stress that parents of a disabled child experienced. This disturbing fact may be due to several factors: The possibility that the available services did not include sufficient psychological counseling for the parents or even an opportunity to discuss problems and feelings with the same person on a regular basis. The attitude of the available professional counselor might at times fail to give parents needed support.

*Waisbren, Susan E. Parents' reaction after the birth of a developmentally retarded child.

Another explanation may be in the design of the social services themselves. These were developed to meet the needs of parents, as those needs were described by parents. Sometimes, however, parents cannot express needs that indicate their own weakness, anger, or hopelessness. They also are often too proud or embarrassed to ask for certain counseling services that might be of value to them. It should be noted that the existence of a service did not always mean that parents knew about it or were eligible for its use. Finally, many professionals were reluctant to recommend nonmedical services.

Parents in this study repeatedly expressed regret that they either did not know about infant programs or were not permitted to use them, often until the child was almost a year old and they were exhausted by having to bear sole responsibility for the child. This was true for parents in both the United States and Denmark, but particularly in the latter, where such programs are rare or unobtainable, except in the case of very severely handicapped infants.

The conclusions of the study are compatibie with the experiences of parents of handicapped children in both countries and in all socioeconomic levels. Parents continue to recall how they were told to "wait and see," or that "things will change," or "you must have patience," even though all professionals in the field know of the importance of early identification and intervention in avoiding or mitigating the severity of developmental problems in the handicapped child. Parents continue to be referred from one examiner to another, often with little coordination of activity among the examiners. And it is still possible to meet parents who have spent as much as several years trying to find an answer to the painful question of what is wrong with their child.

Fortunately, it is possible to establish preventive programs that can reach parents and children before their problems overwhelm them and they despair of help reaching them. Such a program would try to guarantee that—

- Parents are given accurate information about the nature of their child's handicap.
- The information is supplied by a knowledgeable person who has sufficient time to answer questions and to make sure that the answers are understood.

- The information includes a description of what can be done for the child immediately and what services are available now and for later need.
- The parents are referred to a single individual who can act as their contact person in obtaining information and services. This individual should be one they can turn to when they cannot solve a problem or when the service system itself becomes too perplexing.
- Communication between professionals takes place.
- Medical professionals take responsibility for referring children to the proper nonmedical programs (special education services) and vice versa.
- Such (special education) programs, especially those for early infancy, are developed.

The conclusions that can be drawn from such first-hand accounts by parents of handicapped children are important ones to note. Parents should be informed about their child's handicap or the possibility of developmental problems as early and as accurately as possible. This information should also include further advice on what can be done with the problem, where assistance can be obtained, and the nature of the assistance available. Parents will then not only have an understanding of the child's handicap and how it can be helped, they will also learn how they can help the child. This is the first, but the most important, step in a long-range rehabilitation program. It is also the step that will enable the parents to see the rehabilitation program as a totality.

Preventive programs

Preventive programs for expectant and nursing mothers and young children are an important aspect of the new Danish system. The reason for this emphasis is the conviction of most that developmental problems and handicapping conditions can be prevented or alleviated if they are identified and treated at an early age. Under a law enacted in 1945 (revised 1972)* expectant mothers are entitled to five free medical examinations (two of these are post-natal) and to as many health examinations by a midwife as needed. Increased efforts are being made to ensure that all women come for medical examinations in the last trimester. It is also recommended that birth take place in a hospital

*Special Education in Denmark. Copenhagen: The Danish Institute, 1979.

because of the better chance of preventing complications during birth. During the five to eight days the mother and infant stay in the hospital after a normal birth, both are carefully examined and the mother is instructed in care of the newborn. Expectant mothers, together with the fathers, are given an opportunity to participate in courses in preparation for childbirth (natural childbirth) and in basic child care and child psychology.

Preventive medical examinations for children have existed in Denmark for more than thirty years. They are usually performed by the family physician when the child is five weeks; five, ten and fifteen months; and then yearly from the age of two to six. During the school years, the child is examined by the school doctor and nurse. The public health nurse visits the child during the first years and, if necessary, on a regular basis for several more years. The nurse and the family physician are essential for the early identification of children with potential or actual developmental problems. During the past ten years, public health nurses have been taught that the child's emotional and social development is as important as physical development. In most communities, the nurse can now consult with a team consisting of physicians, psychologists, and social workers about problems in the family, thus influencing the development and well-being of the child. This background team should be supplemented by a special education consultant to guarantee that special education services are available to the child who needs them. (It should be noted that in Denmark, but not the United States, all such services, including dental care, are free of charge for everyone.)

Early identification programs

Children with severe handicaps will almost invariably be identified through the health department's preventive medical program. Children with less severe and less obvious handicaps, or those with more general physical or behavioral problems, will often not be identified until they enter nursery or even regular school. Because of the problems of early identification, nursery school teachers, regular teachers, and any other involved parties who suspect developmental problems are obligated to refer the child for further evaluation to determine the need for special services.

The possible ill effects of early identification have been debated in Denmark, with particular concern being voiced about the danger of self-fulfilling prophesies. There is the fear that if children are identified as having special problems, they are likely to be treated accordingly, and the child may develop a condition that fulfills the expectation. Early identification also tends to run counter to a traditional professional approach, which often prefers to mark time before deciding if a real problem exists or if it is simply a case of slow development, with the possibility that the slow starter will catch up without any assistance.

Children do develop at their own individual and unique pace, but there is well-documented proof that early detection and intervention is critically important for the handicapped child. Without such early detection critical periods of learning might be bypassed, and failure to provide special education services or other intervention might cause serious problems for the child at a later point. Slow developing children who may or may not eventually prove to be handicapped are not likely to be harmed by participating in special programs in areas where they do not as yet function well, provided that both parents and children are told why the special program is being made available. Research on the effects of early intervention programs has begun to indicate that children who have such training before regular schooling do better than children who need such services but do not receive them until a later date.

Pre-school programs

It is essential that good pre-school programs, day-care facilities, and nursery schools be available for all handicapped children who need them. The majority of handicapped young children will benefit from a regular day-care or nursery school program which is provided in conjunction with a special education program and some professional assistance. Parents of handicapped children need the support of a good nursery school, which also provides the chance of some time free from the constant care of the child. Such free time can be spent with the handicapped child's siblings, in recreational activities outside the home, and in work, since both parents often are employed.

For the young child, school is not only the most important change in life but also the most normal part of growing up. The

rehabilitation program for the very young child should focus both on the experience of being in a group of different children and on developing some of the specific skills and knowledge that make adjustment to school easier. These experiences are particularly important for handicapped children, who are often deprived of the wide range of experience that nonhandicapped children enjoy daily. The handicapped child is usually told about or shown things that the normal child can learn on his own. Fortunately, many pre-school programs are developing ways in which the severely handicapped child can directly experience more of the environment than was thought possible before. Such programs for systematically involving handicapped children in the pre-school years in "normal" childhood experiences—while demonstrating to parents, teachers, and child-care personnel how it can be done—should be described and researched further in the coming years as one of the major contributions of special education to overall rehabilitation.

Special education in a pre-school program can be offered either directly by special educators or as part of the child's daily program, under the supervision of a special education consultant. Often a combination of both methods should be preferred. In addition to the special program, the child often needs support in practical situations involving interaction with other children and adults and in participation in standard school activities. (It is important that the special education consultant who confers with the parents is also the consultant for the nursery school program where the child is enrolled. This ensures that the parents are kept in close contact with the child's progress and are immediately aware of any special problems and vice versa.)

Not all handicapped children will benefit the most from such a regular pre-school program. A more diversified and flexible system is also necessary so that parents can feel that their individual needs and those of their child are being taken into account. An alternative system, therefore, should be one that offers such things as special day-care centers, special nursery schools, and even temporary institutionalization if necessary.

When a comprehensive special education service for young handicapped children is in operation, there should be fewer cases of children starting school with unidentified or untreated developmental problems. School should no longer mean a traumatic or difficult experience for children who have already re-

ceived special education. On the contrary, the child should be well prepared for the experience of school. There should also be a continuity of consultation, special education, and related forms of assistance, since the school system is also responsible for the education of young handicapped children.

Danish law now requires a careful evaluation and discussion with parents about the needs of young, severely handicapped children who, after receiving comprehensive special education, are about to enter school. This reevaluation is intended to make sure that the education planned for the child is one that, among other alternatives, best meets the child's needs.

Special problems of parents of a handicapped child

Extra financial burdens and the need to supply constant care are among the problems parents of handicapped children face. In Denmark, every effort is made to allow the handicapped child to remain at home. The financial burden on the family is eased by assistance (financial as well as technical and practical) from the social welfare service. This assistance might range from free diaper service to special beds, wheelchairs, technical equipment, alterations in the home itself, and other assistance. Financial assistance is also available to permit a parent to remain at home with the child, or work part time, if this is considered in the best interest of the child. While such financial support is costly, it is still less than the cost of maintaining a child in an institution.

The family's "contact person," the special education consultant, should be able to assist parents in securing services they are entitled to. The contact should also coordinate the many educational, economic, and other types of assistance (often supplied by separate agencies) and bring all available support together to form one overall, comprehensive rehabilitation program, designed to have the optimum effect on the handicapped child and the family. Without this coordination, the family often fails to see the rehabilitation program as a unified approach, whereby they can deal with present problems and plan for the future. They tend to see these efforts as fragmented parts.

Respite care

Families with a handicapped child often talk of the difficulty of finding time to spend with their other children or with activities

outside the home or even getting away for a few hours. They have difficulty in getting a competent person to care for the child or for the older handicapped person who needs special attention. The needs of a family with a handicapped child are like those of other families, but they have, perhaps, an even stronger need to cultivate interests outside the home. They should be encouraged to engage in a variety of social activities, not only for their own sake and the sake of the other children but also for the sake of the handicapped child. Socially isolated families are not able to help a handicapped child relate to other people in a social context.

Institutions are at times able to take in a handicapped child on a short-term basis, which may be of invaluable assistance during family illness or emergency. But this could be a traumatic experience for the handicapped child, possibly leading to regression in functioning, if the institution and its personnel are unfamiliar. Even in emergencies, therefore, it is preferable that a child-care professional watch after the child in its own home.

A group of Danish parents with handicapped children have suggested that a child-care professional should be either a student in a relevant profession, a person with expertise in care of the handicapped, or an individual who is willing to take special courses in dealing with certain kinds of handicaps. Such trained personnel should be part of child-care services established in each municipality and administered by a special school or a special education center. The service, paid for jointly by parents and the social welfare system, should provide evening and weekend care, scheduled sufficiently in advance to allow parents to plan their own activities. The service should also have the resources to deal with emergency requests for assistance.

Special summer programs should also be made available for handicapped pre-school children. Such programs should include both day and overnight programs. These would provide for the child's continuing development during the summer and at the same time give the family a needed respite and a chance for a vacation on their own.

Programs for parents

Parents of young handicapped children should be involved in special programs which will give them the support they need to

cope with the anxieties, depression, guilt, and ambivalent emotions that are part of being a parent of a handicapped child. The opportunity to work through these feelings is as important as the availability of the best social and educational services. Support can be offered through regular sessions with a psychologist or a social worker, either individually or in group sessions with other parents. Many parents find it helpful to share their problems and feelings, their good and bad experiences, with others and possibly learn ways to solve some of the problems.

At times parents avoid becoming involved in their children's programs, either because they are unable to cope with the situation or because they feel inadequate in relation to the professional worker. This reluctance is sometimes interpreted as a lack of interest in or concern for the child. But while professionals should try to involve parents in the child's programs, they should also avoid judging parents who shy away. It may take several years of continued effort and a variety of different approaches before parents feel secure enough to become involved in the child's programs. With sufficient support, understanding, and encouragement almost every parent will become an active participant. The earlier such involvement happens, the less likely parents are to become confused and frustrated about the role they are to play in the child's training or schooling.

This is especially important when the need for an early infant program is discussed. Sometimes these programs are offered individually to the parents by a special consultant who visits the home or the regular day-care program. This could be the best arrangement for some children and parents, but the parents will still need to discuss their problems with a professional or with other parents of children with similar handicaps. Parents groups should be arranged or the parents should be included in existing groups. Siblings of the handicapped child often have problems. Some experiments with sibling groups have been helpful.

Some institutions for the severely handicapped maintain family camps where the handicapped child, the family, and the professional staff from the institution or special schools have an opportunity to become acquainted in a situation other than the usual client-professional relationship. The program includes talks by experts on various handicaps, discussions with special educators and other professionals involved with children, group

discussions for parents while the children are being cared for. The program also includes joint activities for everyone—social gatherings and entertainment.

Parents of institutionalized children should also participate in parents programs. They need the support of other parents and professionals to deal with their frustrations and guilt feelings from not being able to care for their children themselves. If they feel they are not supported by the institution in maintaining contact with the child, the parents may stay away, depriving the child of this essential contact.

The special education consultant

The special education consultant is critical in the overall development of a handicapped child. The consultant is the family's first contact when the handicap is identified, and is the link between home and such outside services as nursery school, day-care program, and medical assistance.

By professional training and experience, the consultant should be able to assist the parent in stimulating the child's development. Through visits to the home—often lasting an entire day—the consultant demonstrates ways of dealing with the child in practical situations, of interacting with the child through play, and of training the child to make maximum use of his or her physical and intellectual capabilities. The consultant may also provide technical aids and certain kinds of training toys, or recommend that they be provided by the local welfare agency. Consultants often help with the medical follow-up, sometimes accompanying parents and child to the physician. (Consultants also should train teachers and child-care personnel in these techniques for dealing with the child in the nursery school or at the day-care center.)

This system of special education consultants exists in Denmark for blind or severely visually handicapped children, for children who are deaf or have severe hearing loss, or for children with serious speech problems. It also includes comprehensive services for children with congenital cleft palate. Such special education consultant programs have not yet been developed for other handicaps, but they should be considered for inclusion in an overall rehabilitation program.

SPECIAL EDUCATION FOR SCHOOLAGE CHILDREN

As previously noted, the new Danish laws make municipalities responsible for regular and ordinary special education. Municipalities and counties are jointly responsible for providing special education and special educational services for the most severely handicapped children. Municipalities must also identify and refer such children to the more specialized, comprehensive services available at the county level. Counties offer handicapped children (from under one year to eighteen years of age) special educational services that would be too specialized, too comprehensive, or too expensive for municipalities to provide. County services range from financial support to provision of special consultants, educators, and a variety of special programs.

Organization of special education

There is no longer any formal distinction between the organization of regular special education and comprehensive special education for children with severe handicaps. The following table of organization is arranged in the order of the least to the most restrictive setting in which special education can take place.

1. Education in a regular classroom with special support.
   - In addition to other forms of special education, individual instruction in a number of lessons in certain cases.
   - Special education in small groups in several weekly lessons.
   - Special education in the regular classroom, two-teacher system, supported by special education teachers and others.
   - Some extra teaching resources, such as small class size, split lessons.
   - Special education materials or necessary technical aids.
2. Special education in certain subjects or skills in resource rooms.
3. Special education in a special class in the local school.
   - Placed next to and interacting with a regular class.
   - Special classes and regular classes join in certain mutual activities.
   - Special classes and regular classes taught together to some extent.

- Special classes and regular classes taught the same subjects and together most of the time.

4. Special education in a special class in a regular school outside the child's normal school district.
5. Special education in a special center connected with a regular school—appendix school, twin school, for example—with various kinds of interaction with the host school.
6. Special education in a separate special school.
7. Special education in a special boarding school.
8. Special education in a hospital setting.

In addition to these arrangements, local school districts also provide a variety of services for a few severely handicapped children.

Referral to special education

Since all children who need special education are entitled to receive it by law, access to the system must be open and uncomplicated. Parents who think their child needs special education should be able to address themselves directly to the school system, the family doctor, or the school. Anyone who recognizes that a child has special needs is obliged to refer the child for further evaluation.

All referrals to special education are based on a psychoeducational evaluation by the school's professional staff. The county special education institution can provide additional assistance, including medical expertise, if it is needed in making this evaluation. An individual education program, based on the evaluation, is then designed for the child. If this program is beyond the capacities of the local school district, the child is referred to the county special educational services. The parents and, when appropriate, the child, are involved in discussions of the most appropriate kind of program. But while parents are always informed about the referral and the evaluation carried out by the school-psychological team, in Denmark the parent may not decide whether or not the child is to be referred to special education. Children are entitled to free public education, but parents cannot choose the class, the programs, or the teach-

ers, although they can participate in the overall planning for the school itself. Parents should be informed regularly about the child's performance and development, and they should participate in the yearly evaluation of the program at the time when new goals are set for the coming year. The school psychological team must, however, be involved in any major change.

It should be noted, however, that the referral system described has not been fully implemented in Denmark as yet. Obstacles to its success come quickly to mind: for one, it is not easy to administer a system in which at least three and often five or more different parties share responsibilities. The goal of the system is to be flexible and uncomplicated, while at the same time involving responsible professionals and public officials in the decisions. Such aims are not necessarily and inevitably in conflict, but they are not always easy to achieve.

Professional assistance to local school districts

The goal of the new Danish laws is a decentralized system for providing handicapped individuals with special education and other services. This intent has led to certain fears, among them the possibility that the professional skills that have been centered in the various state institutions would no longer be available or that handicapped children would no longer derive maximum benefit from that professional expertise. There is also the fear that the pace of research and development in educational techniques would slow down. Regular teachers and even special education teachers on the local level cannot be expected to have the same experience with or knowledge of certain handicapping conditions as do educators who have worked extensively with children with such conditions or have specialized in their treatment.

To overcome these fears and avoid potential dangers, it is recommended that some special education institutions remain as centers for development and research. Such research centers would then have an obligation to share their findings with professionals on the local level. These centers would be able to provide facilities for more detailed evaluation and even longer observation periods when it is difficult to decide on a particular education program for an individual child. Center staff members should be available for consultation on evaluation, referral, spe-

cial education, and counseling activities. Conferences and short courses should also be available for local school district teachers, parents, and children. In certain instances, it might be more convenient to place a teacher from a special education center within a local school district to assist in designing a local program. The consultants should work part time at their profession and part time at their professional function at the center so that they do not lose direct contact with real, practical work and problems.

The foundation of both the decentralization and integration concepts is research, coupled with continued broadening of experience. It is therefore necessary to continue specialized special education, but with the goal of applying the knowledge obtained to special education as a whole. Methods and experiences garnered in studying one handicapping category might well be applied to teaching children with a different type of handicap. Thus a specialization ultimately may benefit not just one particular category of children but all children in special education.

Centers providing special technical and education aids

Moderately and severely handicapped children often need special technical and practical aids in order to function in an educational setting. In Denmark, the counties are now required to establish centers where such aids for adults who are handicapped are obtainable. Professionals who work with children strongly believe, however, that the needs of children are quite different from those of adults. It has been recommended that the County of Copenhagen continue and expand its provisions for supplying handicapped children with such necessary aids.

There are several cogent reasons for supporting this recommendation:

- local school districts do not serve enough handicapped children to develop sufficient information about technical aids
- improvements in such aids are being made so rapidly that equipment is often outdated by the time the next child in a local district needs it
- investment in these aids is too expensive for local districts
- local officials do not have the expertise to determine which aids are required for each particular handicap

- standard aids often have to be adjusted to a particular handicapped child
- technical aids are often so complex that one must work with them on a regular basis if they are to be used correctly
- new specialized aids and the adjustment of standard aids represents a cooperative effort of technical personnel, special educators, therapists, and the medical staff of a specialized institution.

Over the past decade the County of Copenhagen has provided severely handicapped children with such special technical aids as electric wheelchairs and typewriters, specially designed tables, and lighting fixtures as well as more sophisticated equipment such as FM transmitters and receivers for those with severely impaired hearing, microfilm equipment, Braille typewriters, and closed circuit television for those who are visually impaired. Books and tapes are provided by the Institute for the Blind.

Much ingenuity has gone into developing less expensive but useful devices designed to help children eat by themselves, turn the pages of a book, and perform other simple functions. These and other devices testify to the skill and the dedication of the professionals involved in their development.

A new electronic communications system is now being tested in three schools. This system allows children or adults who have no command of any part of their body to communicate in writing merely by a slight movement of any part of the body or by a sound. Children who cannot learn to read or write might be able to use this system in conjunction with a symbol language. These children might be able to answer questions, play games, move a colored light, stop and start an electric toy—in sum, enjoy their first experience of actually making something happen in the physical world.

A center that can provide the best technical and practical aids, without cost, to severely handicapped people would allow them to function better and more independently, and as early in life as possible. All of these are prime requisites if the handicapped individual is to develop to his or her full human potential. In addition to a center for technical aids, there should also be a collection of special toys and games available for the younger children for use at home or school.

A child who has had, from the earliest possible time, the kind of technical and recreational aids described here becomes more resourceful and innovative in using all kinds of aids, devices, and tools. At the same time, this experience enables the child to strive for greater independence, and possibly achieve it, than a child who has become accustomed to rely on adults to have his or her needs satisfied.

After-school programs

Handicapped children of school age should have the opportunity to participate in local community recreational programs. Many handicapped children need only the personal support of an aid to make such participation feasible. Special after-school activities should be offered to even the most severely handicapped children, either because they would benefit from courses or training in specific skills or because they are unable to participate in the regular programs.

In Denmark, the local community Social Welfare Department is responsible for organizing recreational and after-school programs for all children from the age of seven through eighteen, including the handicapped. The county should organize similar programs, including summer programs, for the few who are too severely handicapped to participate in regular local community programs. (Local communities would have to bear the expense of such programs.) All other programs described for pre-school children and their families should continue throughout the school years and even beyond.

Training the special educator

No matter how many technical aids or other forms of assistance are made available to handicapped children, their teachers exert the greatest influence on their development. The need for more and better trained teachers, and better training programs, has been stressed repeatedly in all discussions about special education and integration.

There should be two levels of training of special educators:

1. Consultants: special educators who have a solid academic training in specific handicapping conditions, combined with broad practical experience. Consultants should hold a doctorate or certificate level of university training.

2. Special education teachers: teachers who in addition to regular training hold a master's degree in special education. They should have practical experience of both regular and special education situations.

In-service training

Both consultants and special education teachers should have available to them additional courses in which they can learn about new techniques, new materials, and new developments in the field. Regular teachers who have handicapped children in their classrooms should be offered courses in teaching specific skills and in the basic principles of teaching handicapped children. Particular stress should be placed on the social and psychological implications of the handicapping condition they must deal with. Teachers' aids and others who assist regular or special teachers should also receive basic instruction in how best to manage the handicapped child. Special education centers or institutions should be responsible for training on this level, while the regular training of special educators or consultants should be the responsibility of the universities.

Integrating severely handicapped children

The research project described here was undertaken by Svend Ellehammer Andersen and Bjorn E. Holstein of The Royal Danish School of Educational Studies in 1979.

Until January 1, 1980, Danish law required that blind children attend a special boarding school for ten years. In spite of the compulsory nature of the law, the practice of granting exemptions from the requirement was so extensive (particularly from the 1960s on) that practically all visually handicapped children attended the public school system, unless such special conditions as the existence of other handicaps or family problems prevented it. Thus over a period of fifteen to twenty years there was a radical change in the educational practice and even in the general attitude toward blind or visually handicapped children, even though there was some resistance from those who favored the traditional special school system.

As changes in the law were about to take place, a study of the de facto integration of children with severe visual impairment

over the past decade or so would be of great value in anticipating results of the proposed changes that would mandate integration for all handicapped children. This was the origin of the study discussed here.

The study enumerates five principles on which successful teaching of the blind must be based: individualization, provision of concrete experiences, provision of total rather than fragmented experiences, reality attachment, and active learning.

The study showed that only the first of these principles, individualization, was normally applied; the other four did not influence the teaching of "integrated" blind children with no evidence that the other principles had been part of their educational experience. Teaching was not adapted to the special learning situation of blind children. Blind students did receive special materials and teaching aids, often in excess of actual need. Supplementary teaching hours had also increased in the period studied. Yet the use of supplementary teachers introduced new problems. In some cases, these teachers were felt to be reinforcing the handicap and isolating the blind students from natural social relationships with classmates, rather than attempting to overcome the problem of isolation.

The role of the sight consultant was found to be critically important in helping to integrate blind children in the regular school system. When sight consultants moved from the state school system to the local public school, integration of the severely handicapped children progressed rapidly.

The role of the sight consultant

Most sight consultants are now employed by the counties but work within local school districts. They function on the diagnostic, counseling, teaching, and coordinating levels. Sight consultants also plan school placement of pre-school children who are either congenitally blind or who have severe sight impairment. The consultant works with the child's future teachers in the receiving school district, visits the classroom, and discusses with parents and teachers the kind of program and assistance the child might need. In the period immediately after the child enters school, the consultant usually takes an active role in instructing the child, the teachers, and even the parents. The consultant continues to monitor the child's progress, offering sup-

port to all concerned and thus serving as the contact person for the child and family throughout the school career. In the County of Copenhagen it is proposed to integrate the services of the pre-school consultant with those now delivered by the consultants for schoolage children, and possibly to extend the services to include adults now being served in part by former state institutions.

The study concludes that while it is fully possible to integrate blind students into regular schools, in actuality integration has been on a low level in Denmark. Good examples of mutual attraction between blind students and their classmates have been found, but there are few instances of mutual dependence.

The five basic principles of teaching the blind were not being applied in the schools; as a result, blind students were often being taught parallel to their classmates. They were being assimilated rather than truly integrated into the whole educational situation. As a consequence, the specific skill level of blind students remained somewhat low.

The study also notes that successful integration depends in part on the ability of visually handicapped students to deal adequately with the problems caused by their handicap. By the same token, integration also depends on the ability of the non-handicapped students, and the adults in the educational situation, to confront problems as they arise and look for appropriate solutions.

The study presents several recommendations which are believed will assist in the integration process of the visually handicapped:

- They should be encouraged to demand their rights.
- They should be provided with total rather than fragmented experiences.
- Those who do not function well in regular programs should be offered programs and situations where they might function better.
- The entire educational environment, rather than the individual handicapped child, should be the focus of attention, and all concerned should learn how to function more effectively with that environment.
- The educational level of sight consultants, teachers, and supplementary teachers should be improved.

- Educational and social activities should be coordinated so that the individual student benefits from the resulting co-operative effort.
- Activities directly related to the handicapped student should be carefully coordinated. A critical evaluation of this area is the basis for improvement in the total situation.

This study is important for several reasons. It is the first comprehensive examination of the majority of blind students who have been integrated into a regular school system. It is, moreover, the only comprehensive study of the integration of severely handicapped students. The study incorporates recent data. Most important, however, is the fact that its conclusions and observations can be applied to the integration of children with severe handicaps of any kind, not just visual impairment.

The study's general conclusions are confirmed by the findings of many studies about integration and by the many discussions between teachers and parents prompted by the introduction of the new education laws in Denmark. The study concludes that social integration can be effectively implemented, but that integration has a number of shortcomings in terms of the total development of the handicapped child. If, as the study points out, blind children are often assimilated rather than integrated into the educational situation, and if the curriculum is not changed to meet their needs, it can only be assumed that children with other handicaps will have the same experience with integration. (Some children may meet with even less success. It should be remembered that blindness or severe visual impairment is a socially accepted handicap; that is, it is one that meets with general social acceptance and positive response. This is not necessarily true of other handicapping conditions.)

If the skill level of integrated blind children remains relatively low, there is little reason to assume that children with other types of severe handicaps will be taught specific skills faster or more thoroughly in an integrated setting. It is significant that the many reports on integrating children with various handicaps all focus on the positive social adjustment that the child makes, while paying less attention to other aspects of the child's development. Social integration may be an initial step, but it must be completed by a full realization of the recommendations that the authors of the study make. If these recommendations are

not carried out, special education in the integrated situation becomes merely supplementary teaching, a continuing effort to make the handicapped student learn in a parallel path to regular students.

To avoid this, it should be strongly recommended that alternate special education centers or special schools be developed. Here the severely handicapped child and young adult would have an opportunity to learn the specific skills they need to function independently. Such special education centers, placed in or adjacent to the regular school buildings, should function in close cooperation with the host school and with the local school system. The severely handicapped student should be offered all or part of his or her education at these centers. If the centers are to become alternatives to special education in mainstream situations, they must develop programs based on educational principles such as previously indicated for blind and visually handicapped students. (The curriculum in such centers does not, however, have to be patterned on that of the regular school. There is no need, for example, for a rigid format of forty-five-minute periods and different instructors for each subject.)

For the bright handicapped child, there is no doubt that integration, with the necessary technical and/or professional support, is the most effective and natural part of a total rehabilitation program. For the less intellectually gifted child, or for those with multiple handicaps, an integrated educational program cannot be expected to meet the requirements of an overall rehabilitation program, unless integration is combined with alternative programs offered by the special education center or schools. The combination of mainstream and special programs should be tailored to the needs of the individual student and can range from alternating periods in each program from year to year, to daily exchanges between each type. Recreational programs and special courses should also be considered.

For children with severe multihandicaps, the special education center might offer the best education and the most stimulating program. This should not, however, exclude the possibility of daily participation in all or some of the host school's nonacademic programs. In the same manner, children from the regular programs might benefit from participation in activities of the special education center.

New schools must be planned and built so that they can accommodate handicapped children. This should not prevent such schools from offering services to nonhandicapped students as well. In Denmark recently a new building for children with severe orthopedic handicaps was planned as part of a special education center that is "host" school for a regular district school as well.

In order for a handicapped child to secure the kind of special education that will enable him or her to develop fully, it is essential that knowledge about specific handicaps be increased, that sound educational principles be applied to individual training and schooling, and that integration on various levels be attempted. A wide range of educational alternatives should be available, and special consultants should be present to explain the advantages and limitations of each program to parents and children. Additional services and greater flexibility can be secured through the development of a comprehensive special education system serving a larger geographic area (the county).

SPECIAL EDUCATION FOR ADULTS

As previously noted, the new Danish special education regulations secure for the first time the general right of any handicapped person to special education beyond the compulsory nine years of schooling (or after eleven years for some severely handicapped individuals). The law applies to adults as well as children. But although there are no legal distinctions between young adults (ages eighteen through twenty-two) and older adults, there are important differences in educational needs and programs.

Young adults

Under the former Danish law, most severely handicapped children attended compulsory school until the age of twenty-one. Compulsory education now ends after nine years of school, generally when the person is sixteen. This does not, however, mean that the handicapped person's right to education ends at that time. In all regular school programs, some vocational orientation is offered in the last years of school. In addition, there are two periods of vocational practice, when the individual has the opportunity to spend two one-week periods in a work situation of his or her choice.

Such vocational orientation programs should be available to moderately and severely handicapped children who are unable to continue either an academic or a technical education. In some local school districts, special classes, led by the special education consultant in cooperation with the vocational consultant, have established programs in which the child attends school half a day and a workshop for the other half. It should also be possible for the child to start regular vocational training while still attending school. This training could be on several levels, from actually acquiring a vocational skill to preparation to enter a sheltered workshop. It is important to train moderately and severely handicapped individuals in some skills, regardless of the level of complexity, so that they may function better in adult life. Since these young people take longer to learn, it is important that adequate time be given to preparation and to instruction. Time is often more profitably spent in this area than in traditional academic subjects that are less significant to the handicapped individual and are less meaningful in terms of his or her actual life situation.

In a recent Danish follow-up study of young handicapped adults who had attended special classes, the former students complained that they felt unprepared for life after school. Their parents also worried about the sudden lack of protection and services for their children. In no case had any of the students received direct preparation or training for a future occupation or job. At most there had been some counseling about how to go about seeking employment. These young adults were not severely handicapped, and although they would probably not have benefited from advanced academic study, most of them probably could have learned various skills through alternative teaching methods, including practical demonstration and practice. As it was, many of these young adults were unemployed or were working at inferior jobs.

Even less severely handicapped individuals who have received special education in regular schools often encounter problems when they leave school. The same study discusses the transition from school to work with both parents and the young persons. Most seemed to share the feelings described in the following comments:

> "I think we lost contact with the school too abruptly. There should have been a transition period when you could talk with the teachers and get advice and guidance. There should be a smoother transition."

> "I think the counselor should have helped us find something to work at, because we've only had odd jobs. I think we could have used more help because it is difficult for us to find work. There should have been two or three years when we were a little sheltered, too."

Anticipating problems that might occur after special schooling is also a source of anxiety. A father of a borderline psychotic twelve-year-old girl expressed these feelings:

> "If resources are not sufficient to meet every need, I think priority should be given to services that prepare the child for adult life. When my child was young, we thought she was not that different from others and that she did pretty well with other children. Now that she is older, we have to realize that she will never be able to take care of herself. She will be totally isolated if she cannot live in a sheltered

arrangement, work in a protected environment, and be helped to take part in recreational activities. She will probably be able to enjoy planned activities all her life. She would suffer greatly if placed in an institution like a nursing home. We helped and took care of her when she was young, but now it's getting difficult for us to provide for her and help her meet and be with other children. We dread the day she will leave school. What then? There will be many more years to her adult life than there have been to her childhood, and we are getting older."

Young persons with severe handicaps (particularly mental or orthopedic handicaps) are often kept in a children's special educational program because there are no opportunities for continued educational or vocational training available. All too often placement in a nursing home is the only alternative to remaining in a family home and subsisting on an invalid pension.

The transition from childhood to young adulthood is thus in many respects the weakest link in the overall rehabilitation program. Even special education does not fill this gap. Greater efforts must be made to develop programs to continue education beyond the childhood years, to help the handicapped individual develop additional skills, and to see that the skills that are acquired are kept operative by daily use.

Four important areas should be included in developing preparatory programs for young handicapped adults: continued education, daily environment, occupational preparation, and recreational programs.

Continued education. Many young adults would benefit from full educational programs after compulsory education ends. Such education should not be given in the same school or with the same teachers, since the young adult must now see him or herself as a more mature individual, with more independence and responsibilities (if this is possible). The education program should focus on developing the kind of skills that will enable the individual to function more independently in adult life. This training should also include such commonplace—but for the handicapped often problem-ridden—activities as preparing a simple meal, shopping in a market, taking public transportation, and tending to personal needs. These things are taught in careful step-by-step detail at special youth schools.

In Denmark, a severely handicapped person over the age of fifteen receives an invalid pension. Teaching young adults how to manage a pension or earned money should also be part of the continuing education program. Finally, the entire education program should be coordinated with the sheltered workshop training or day-care programs, which are run by the social welfare system for the most severely handicapped.

The need for special youth school programs coordinated with vocational training, workshop preparation, and work experience is acute in Denmark. (Such schools are available for the mentally retarded who have attended the former state school system.) The same programs are as critically needed for moderately handicapped young persons who have attended regular school programs or regular special education programs. These persons very often find that they are not equipped to meet the demands of a job or life in the world outside the school.

A recent report, "Youngsters with Delayed Development and Society," (Copenhagen, 1979), describes the difficulties slow learners face in trying to function in an ever increasingly complex world. Based on extensive interviews with such young persons and their parents, the report makes the following conclusions about special education: Special education often has limited potential for teaching necessary skills to young persons with developmental problems. The question remains as to what type of program or education would best open up areas of potential development in these individuals. Ongoing experiments show that academic skills are improved when a method of instruction based on concrete examples is used.

The report suggests that developmental centers be established to act as supplements to the kind of academic training given in local public schools. These centers would be more closely in contact with the local community than the schools. They would be able to offer vocational training, a combination of job training and actual work experience, and would also serve as a job placement agency for the students.

The report also suggests that unions and trade organizations accept demonstrations of practical skills in lieu of any formal examination or similar qualifying procedures for holding a position.

In summary, it can be said that a rehabilitation program should include the possibility of continued full-time special ed-

ucation, combined with vocational training, workshop programs, and work experiments in special youth schools or centers.

Daily environment. Many handicapped young persons are overprotected and too sheltered by their parents to develop independence. In order to build a sense of independence, young adults should have the opportunity to stay at a youth hostel or similar establishment where they can gradually take responsibility for as many of their personal needs as possible. United Cerebral Palsy of New York has developed a number of alternative living arrangements, from nursing homes to clusters of apartments, where the severely handicapped live independent lives and are provided with just a limited range of services. As the individual develops more skill and confidence in handling practical tasks in daily living, he or she moves from a sheltered to a more self-determined way of living. Along the same lines as the New York experiments, a separate dormitory or, even better, a part of a regular dormitory or youth hostel can be maintained for handicapped students who live away from home while attending school.

Occupational preparation. The most important function of a special youth school program is to make the transition from school to work—from childhood to adulthood—easier and more meaningful for the handicapped individual.

Continuing special education should be coordinated with a variety of occupational evaluations and actual work experiences at various levels, including actual work situations, sheltered workshops, and day-care centers. The special educator may often be able to develop new ways of teaching specific skills needed to perform in a particular workshop. The educator or other specialist may also devise ways of adjusting work areas, tools, or other equipment so that these may be more readily used by the handicapped.

Young adults with handicaps should be acquainted with various kinds of workshops available at the youth school before being introduced to an outside workshop or work situation. They will have to be helped to make a number of necessary adjustments: learning to work as part of a team, adjusting to regular working periods, finishing or producing only one part of a project that they may not bring home as they did in primary school.

These and other changes might be overwhelming for the unprepared handicapped person, preventing him or her from doing as well as he might had he been prepared for the changes.

The young adult will also have to be instructed about the meaning of pay for work performed, and about how to use the salary earned. A trial period may be beneficial in overcoming these and other problems. During this period the individual will spend time in a number of different workshops or work situations before a final decision is made as to which would be best suited.

Recreational programs. In Denmark there are no requirements for the provision of recreational programs for young adults over the age of eighteen. It is left to parent organizations or other private groups to set up such programs for the severely handicapped who cannot participate in clubs and other recreational programs for adults or young people. Private organizations in both Denmark and the United States have fortunately been quite active in setting up recreational programs, but the full burden should not fall on this private initiative. Rather, the local municipalities, perhaps in conjunction with the counties, should be responsible for providing a variety of programs for young adults. In some cases it might be possible to add extra resources to existing regular programs; in other cases special programs may be necessary. Teachers or consultants from the youth school will have to introduce the young person to the programs, since severely handicapped young people rarely are able to take the initiative alone or to have the practical arrangements made to attend such a program. They should also be taught where and how to find out about available programs and how to enroll in them. Most important, however, is that such programs must be available.

Involvement in a work situation

After a full-time education program of up to fifteen years, the rehabilitation program for the young adult should shift emphasis from formal academic training to involvement in a work situation, either in a sheltered workshop or possibly in an ordinary factory or shop.

Present unemployment in Denmark makes the need for a variety of sheltered workshops greater than before. Day centers

for the most severely handicapped young adults would guarantee that all would be meaningfully occupied for at least part of every day. The ideal is to offer every handicapped person eight hours of occupation outside the home or institution, provided the individual's physical condition permits.

The new Danish law on special education secures the right of special education as needed for all handicapped adults. The role of this education in a total rehabilitation program should be in the planning and implementation of ways to teach new skills or impart new knowledge, based on an evaluation of the individual needs. Existing skills should also be improved and maintained.

Special education for adults can involve teaching those who have a laryngectomy to talk again, teaching mobility techniques and Braille to the blind, teaching sign language or other communication systems to the deaf, and teaching the mentally retarded such practical skills as preparing meals, using public transportation, and managing money.

Special education can be useful in all areas of adult life, when learning a specific skill or technique would bring greater independence and self-reliance. It cannot, except in such mild instances as reading and spelling difficulties, alone solve the problem created by a handicap. Special education is therefore a supplement to other services in a rehabilitation program and must be planned and carried through in coordination with those services. Neither special education, medical services, nor social services alone will provide comprehensive rehabilitation.

The special education teacher or consultant is the most logical coordinator for the rehabilitation program as long as the child or young adult attends school full time. After this schooling period, a coordinator from the social service system or an institution can best deal with all the services required. This individual acts as the contact person to insure that the handicapped young adult or adult obtains needed services. Consultants for adults with specific handicaps are appointed by the state. These consultants are particularly important for people who become handicapped in adult life. Some state consultants are particularly good models because they have the same handicapping condition as their clients.

No formal referral is needed to obtain special education for adults, although the program should be based on a psycho-ed-

ucational evaluation as well as a physical examination. In Denmark there has been more public interest in innovative programs for handicapped children than for adults. The new law should make it possible to develop a more coherent and comprehensive system, one in which special institutes offer their expertise and experience to other schools and centers. This interchange of knowledge and ideas should prove of particular benefit for adults with multihandicaps.

Naturally, adults with handicaps have the same need to take part in appropriate recreational programs and to live and work as independently as possible as younger adults. Each municipality is responsible for providing these adults with support to enable them to stay in their own homes as long as possible. This support might be direct assistance from a home-helper who visits daily, or the provision of technical aids. A special educator might help teach newly handicapped persons the necessary skills to function better in the home situation also.

CONCLUSIONS

It can be said that a system of comprehensive service for the handicapped must not attempt to take over all responsibility and decision making from either the handicapped individual or the parents. The desire to serve, assist, or protect the handicapped must not be at the expense of personal initiative or personal identity. Handicapped persons are not anonymous, but are individuals in their own right, with special needs that must be taken into consideration.

A comprehensive rehabilitation program is one that secures for persons with a handicap the support necessary to help them develop and function in all areas of life, growing to their full potential. Even when the handicap is so severe that it is difficult to determine what if any potential might exist, no effort should be spared to find out and utilize this potential. The goals of the rehabilitation program should be based on the concepts of normalization and decentralization. People with a handicap should be secure in the same rights as other citizens, guaranteed by the same laws that apply to all. These rights include medical and health services; dental care; education, including special education; social services, and whatever supportive additional services are necessary, in accordance with individual need.

Handicapped individuals should have the right to live, to work, and to spend their free time as independently as they choose. To make this possible, and to maximize the possibility of individual choice, alternative programs and services should be available in all areas. Any child, young person, or adult with a handicap should have the right to associate with people with a similar condition as well as with those who do not have handicaps.

Cooperation among professionals is the best way of evaluating the handicapped individual's total needs, and the best way of planning and carrying through a daily and a long-term program of support and development. But since education is the most "normal" and standardized part of the daily life of children and young adults, the special education system should be responsible for coordinating and implementing services over the long term. A special education consultant or teacher should be appointed for each family with a handicapped child or young adult. This person acts as the direct line between the handicapped and the entire system of social services.

The studies and experiences described in this monograph have shown that integrating even severely handicapped children in regular classrooms is possible. They have also shown that integration alone does not satisfy all the requirements of a comprehensive rehabilitation program for every handicapped individual. The task for the coming years will be to discover the best combination of special education and supportive care that will help the handicapped to develop and function according to his or her potential, in all areas of human development. Increased effort should be made to see that the results of research, innovative programs, and direct experience are shared on an international level. All rehabilitation programs must be based on respect for the individual. In the context of equal rights must also be included the right to risk, to challenge, to succeed, and even to fail. The challenge in the coming years will be to develop systems which combine security and opportunity in long-range rehabilitation programs with flexibility and individual arrangements.

CHECKLIST FOR AN OVERALL REHABILITATION PROGRAM

Age 0—6 (pre-school)

1. Comprehensive (preventive) services during pregnancy
   ——medical checkups
   ——birth preparation
   ——preventive examination in special cases

2. Preventive services during birth
   ——(free) hospitalization
   ——(free) care in hospital after birth
   ——(free) checkups of infant before going home from hospital
   ——careful explanations/counseling/guidance in all situations where handicaps are apparent or potential

3. Preventive services during first year of life
   ——regular visits by public health nurse
   ——regular medical checkups
   ——mother (father) maternity leave (three months)
   ——day-care centers for infants

4. Services for children with handicaps during first year of life
   ——accurate information about handicapping conditions
   ——referral/contact to service system immediately in connection with first information
   ——supportive services to parents (psychological/practical/economic)
   ——special educational services-early intervention programs available
   ——coordination of the results of examinations, evaluations (team approach)
   ——one contact person who will assist parents in receiving appropriate services (special education consultant)
   ——possibilities (requirements) of taking the family's individual needs into consideration
   ——planning ahead for future needs
   ——special respite care (weekend, summer, emergency programs)

5. Nursery school age
   ——nursery schools/special nursery school programs
   ——ordinary nursery schools with supportive services
   ——special educational services in nursery school or at home involving parents in special education programs
   ——continuation of supportive services for parents and family

Schoolage children

——free public education (one law) including special education
——organization of special education (flexible, alternatives)
——coordination with other services (social, health)
——individual education/treatment
——programs based on a psycho-educational evaluation
——regular reevaluation
——parents' involvement
——after-school programs
——free-time activities (sports, clubs, hobbies, etc.)
——weekend/summer programs
——child should be taught in as close to a regular educational situation as possible (mainstreaming/integration)
——special education should be part of overall rehabilitation program and should prepare moderately and severely handicapped students for life after school
——flexibility in programs making it possible for children to change school according to need
——fulfilling the seven recommendations

Special services for adults with handicaps

1. Right to special education
   ——right to continued education
   ——right to special education focusing on specific skills
   ——right to maintain and improve knowledge

2. Living situation
   ——independent living with practical/economic support
   ——"dormitories"
   ——sheltered apartments
   ——institutions (own room)
   ——right to choice between alternatives

3. Work
   ——preference of handicapped in public/private agencies
   ——occupational training
   ——work under sheltered conditions
   ——sheltered workshops
   ——day-care centers with various occupations
   ——eight hours' occupation outside home or institution

4. Free time
   ——social experience in free time
   ——activities (sports, hobbies, interests)

——weekend/evening arrangements
——vacation (traveling)
——small living units (small institutions)
——own room
——good facilities
——living facilities close to public facilities (not removed in the country)
——sufficient orientation/information programs
——one personal contact person (caseworker)
——availability of service does not depend on a specific diagnosis but on the needs of the person with handicaps
——normalization; the laws are the same for citizens with or without handicaps
——all services are free with the exception of services that people "normally" pay
——parents are involved in decisions about their children
——respect for the individual

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U.S. COMMENTARIES ON "THE ROLE OF SPECIAL EDUCATION IN AN OVERALL REHABILITATION PROGRAM" BY BIRGIT DYSSEGAARD

Special Education and Vocational Rehabilitation—Donn E. Brolin 67

Special Education in Denmark and the United States—Helen Jacoby-Blanchard 73

Implementing P.L. 94-142—Patricia Dvonch 75

Comprehensive Programming through Local Communities—Rick Heber 79

The Interface of Special Education and Rehabilitation Services—Robert A. Stodden 81

The Interface of Special Education and Rehabilitation: A Continuum of Commitment

A two-day conference cosponsored by
World Rehabilitation Fund, Inc. and
George Washington University

On September 24-26, 1980, a two-day conference "The Interface of Special Education and Rehabilitation: A Continuum of Commitment" was held, cosponsored by the World Rehabilitation Fund, Inc. and George Washington University, using this monograph as a stimulus for discussion along with talks by Donn Brolin, Robert Stodden, and Carole Peterson. The purpose of the conference was to bring together several key people in rehabilitation counseling, special education (and therapeutic recreation) to discuss some of the issues which the topic and the monograph provoke and to make recommendations for future action.

What follows here are the topic areas which were discussed along with a number of the issues which relate to the topic areas, some of which were discussed at this conference. Following that section is a conference agenda. It is hoped that by presenting this material as an accompaniment to the monograph, other institutions will be encouraged to conduct interdisciplinary meetings of this kind.

A report of the recommendations which resulted from this conference will be available from either of the following:

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AGENDA

THE INTERFACE OF SPECIAL EDUCATION AND REHABILITATION: A CONTINUUM OF COMMITMENT

A Conference co-hosted by World Rehabilitation Fund, Inc., and George Washington University

September 24-26, 1980

Sheraton National Center, Arlington, Virginia

September 24

5:00 - 8:00 p.m. Registration

8:00 - 9:00 p.m. OPENING SESSION (South Ballroom)

Greetings from co-hosts

Eugene W. Kelly, Jr., Dean
George Washington University
School of Education and Human Development

James F. Garrett, Ph.D.
Executive Vice President
World Rehabilitation Fund, Inc.

CHAIR: George Engstrom

Opening Remarks

Margaret J. Giannini, M.D.
Director, National Institute of Handicapped Research

Introductions

Keynote Talk

Dr. Birgit Dyssegaard, Danish Expert, "The Role of Special Education in an Overall Rehabilitation Program"

9:00 - 10:30 No-host reception

September 25

8:30 - 9:00 a.m. Continental breakfast
NORTH 2

CHAIR: James F. Garrett, Ph.D.

9:00 - 10:30 a.m. U.S. EXPERTS SPEAK OUT

Robert Stodden
Boston College
"On the Interface"

Carol Ann Peterson
University of Illinois
"Therapeutic Recreation: An Essential Component of Rehabilitation and Special Education"

Donn Brolin
University of Missouri-Columbia
"Special Education and Rehabilitation: It's Time To Get Together Again"

10:30 a.m. Coffee break

11:00 - 11:45 a.m. Participant reaction to speakers

12:00 - 1:45 p.m. LUNCHEON

CHAIR: J.F. Garrett, Ph.D.

Speakers

Dr. Edwin Martin
Assistant Secretary for Special Education and Rehabilitative Services

Dr. Patria Forsythe
Staff Director, Subcommittee on the Handicapped
Committee on Human Resources

1:45 - 2:00 p.m. John Muthard, Ph.D., to present the charge for the afternoon

2:15 - 5:15 p.m. SMALL GROUP DISCUSSIONS

What Can We Do?
Identifying the critical issues:
Implications for U.S. programs and individual organizations

6:00 - 8:00 p.m. RECEPTION

SEPTEMBER 26

8:30 - 9:00 a.m. Continental breakfast

9:00 - 12:00 noon All participants meet in North 2

CHAIR: John Muthard

Reports on most critical issues and recommendations for action from small group facilitators

Panelists react with additional recommendations

1. FINANCING

All issues regarding financial resources (how, who, why, and how much) for providing education, training, and placement services to handicapped individuals, as well as the financing of related services and programs.

A. What actions at the local, state, and federal level can be taken to facilitate interdisciplinary programs?

B. How do interdisciplinary approaches create cost effective programs?

C. How can grant support be directed to interdisciplinary endeavors?

D. What patterns of funding would facilitate comprehensive programs and services for the disabled child and adult?

2. PERSONNEL PREPARATION

Methods, levels, philosophy, content, structure of in-service and preservice programs designed to prepare professionals (and paraprofessionals) in the fields of education, counseling, training, rehabilitation, and placement of handicapped individuals.

A. Need to specify the objectives which rehabilitation counseling, special education, and recreation therapy programs should set to better qualify their graduates to function more effectively in serving the comprehensive needs of the handicapped.

B. Do special education and vocational rehabilitation training programs in universities need curriculum revision?

C. What is the role of vocational assessment in special education and rehabilitation?

D. Need for special education and rehabilitation personnel to better understand how therapeutic recreation can assist in achieving cognitive, perceptual-motor, sensory, social, and treatment goals.

E. How do personnel preparation programs at all levels stress the team approach?

F. What curriculum areas are similar and best taught in interdisciplinary teams?

G. How can institutions of higher education develop interdisciplinary teaching approaches?

3. PROGRAMMING

The structure, content, frequency, and philosophy of programs designed to deliver education, rehabilitation, training, and placement services to handicapped individuals, and with the program structure and philosophy of related services and training programs, including career development. The latter includes developing pre-high school career awareness programming; infusing career development concepts into the preparation of elementary and regular secondary level educators; developing career counseling services for handicapped students; and providing post-secondary vocational education opportunities.

A. Should special education and rehabilitation be partners or should one begin where the other stops?

B. How can special education and rehabilitation be significantly linked in practice?

C. What about continuing (ongoing) education toward independence and integration of the handicapped in the community?

D. What is the role of vocational assessment in special education and rehabilitation?

E. How can the focus of services for disabled children and adults be kept on increasing independence rather than on encouraging dependence?

4. LEGISLATION

The process of legislation, the philosophy of legislation, and common issues created by two or more related pieces of legislation.

A. How does legislation prevent or promote interdisciplinary cooperation?

B. What is the legislative intent of specific laws, e.g., PL 94-142, 95-602?

5. INTERAGENCY COOPERATION

The need for related service agencies planning and the techniques for delivering services in a coordinated and cooperative fashion. Since a disabled person may require the services of several independent agencies in sequential order, one agency must build upon the services of another or augment those services in a concurrent manner. Cooperating agencies include special education, vocational education, vocational rehabilitation, sheltered workshops, employment service, CETA, and others.

A. Should special education and rehabilitation be partners or should one begin where the other stops?

B. How can special education, career development, vocational rehabilitation, and recreation be linked to the needs and demands of the community?

C. Need for clarification of the functioning of the team process in relation to total delivery of special education and rehabilitation services.

D. How can the focus of services for disabled children and adults be kept on increasing independence rather than on encouraging dependence?

E. When should the vocational and career preparation of people with handicaps begin?

F. How should the vocational and career preparation be provided?

G. How can professionals in special education and in rehabilitation work together to overcome attitudinal and institutional barriers which interfere with the educational, social, and vocational development of the handicapped?

H. What is the role of special education in vocational rehabilitation of adults; for example, the management of academic deficiencies in adults?

I. What existing models best facilitate integrated service delivery?

6. RESEARCH NEEDS AND PROGRAM EVALUATION
Including but not limited to the following:

A. What kinds of information do practitioners in special education and rehabilitation need to enhance service delivery and inter-discipline cooperation?

B. How can the needs of practitioners best be conveyed to those concerned with research?

C. How can cooperation be enhanced?

D. How can the concept of research utilization cut across special education and rehabilitation?

E. How can the effectiveness of interdisciplinary programs best be evaluated? How can job performance be monitored?

7. CONSUMER ADVOCACY AND ATTITUDINAL BARRIERS TO ACCEPTANCE OF THE DISABLED PERSON
Including but not limited to the following:

A. How do the philosophies and perceptions of special educators and rehabilitation personnel impact on the disabled adolescent who is being educated?

B. How do attitudes of parents affect the process?

C. What role can consumer advocate groups play in attitude modification?

D. What is the interaction between the recreation experience and attitude change?

E. What attitudinal barriers exist that prevent interaction among professionals?

F. What is the relationship between continuing education toward independence and integration of the handicapped in the community?

G. How can special education, career development, vocational rehabilitation and recreation be linked to the needs and demands of the community?

H. What role should advocacy groups play in the interfacing of special education and vocational rehabilitation?

8. THE ENVIRONMENT: TECHNOLOGY FOR ACCESS
Technology in the classroom, rehabilitation and training facilities, the workplace, and in recreation.

A. How and where could technical aid display units be established and how would special educators, rehabilitationists, and recreation therapists make use of such centers?

B. How can simple technology and imagination be used to solve problems of access?

C. How and for what purposes could and should funds be raised in the community to promote access?

D. How can special educators, rehabilitationists, and recreation therapists work together to raise funds to insure access to each others' programs?

TASK SEQUENCE FOR GROUP ACTIVITIES

	Suggested time for completion
1. Team Meeting Discuss Assigned Issues (Brainstorm and codify issues	Thursday 2:15 - 2:50 p.m.
2. Team Meeting Prioritize Issues (Rank order issues and select top three)	Thursday 2:50 - 3:15 p.m.
3. Team Meeting Specifically Define Each Priority Issue	Thursday 3:15 - 3:40 p.m.
4. Team Meeting Develop Recommendations for Resolution (What, how, who)	Thursday 3:40 - 5:15 p.m. (include afternoon coffee break)
5. Individual Reaction Summary Session	Friday

EVALUATION FORM

Name _____

Field: Rehab. counseling _____
Special education _____
Recreation _____
Other (identify) _____

1. Was the monograph useful?

|_____|_____|_____|_____|
of little use very useful

2. In what ways?

3. What could you or your colleagues do or what have you done to improve the interface of special education and rehabilitation?

4. Did the small group discussions suggest any new ideas?

5. What could colleagues in other disciplines do to improve the interface of special education and rehabilitation; for example, if you are in rehabilitation, what could people in special education/recreation do and vice versa?

6. To what extent was the structure of the conference (presentation of author, reactors, small groups) useful?

|_____|_____|_____|_____|
very little very much

7. To what extent were the small groups stimulating or helpful in opening up new approaches to deal with issues at the interface of special education and rehabilitation?

very little ——— very much

8. How effective has the conference been in sensitizing you to issues at the interface of special education and rehabilitation?

very little ——— very much

9. What suggestions do you have for further dimensions on this topic?

THANK YOU. PLEASE LEAVE WITH CONFERENCE STAFF

SPECIAL EDUCATION AND VOCATIONAL REHABILITATION: IT'S TIME TO GET TOGETHER AGAIN!

Donn E. Brolin, Ph.D.

Special education and vocational rehabilitation in the United States have a long history of cooperative endeavors. In the 1950s and 1960s, work-study programs involving vocational rehabilitation counselors with the state agency were instituted in many high schools across the country. Because few special educators were knowledgeable of vocational programming and resources, the vocational counselor became an essential part of the work-study program and a key to its effective operation. Some VR counselors had school populations exclusively, and many were situated in the educational facility. Several special education/vocational rehabilitation conferences and training institutes were undertaken in the 60s to promote these programmatic efforts.

The combination of academic and vocational studies was an improvement over the traditional academic-oriented curriculum that had exemplified special education in previous years. Follow-up studies of graduates comparing the outcome of those who received the traditional versus work-study emphasis generally revealed a more favorable outcome for the latter group of individuals (Brolin et al., 1975; Chaffin et al., 1971; Kokaska, 1968; and others). However, these studies also revealed that even after combining academic and vocational preparation, a substantial number still had serious vocational adjustment problems after leaving the educational system.

The concept of career education was introduced to American education in 1971 by Dr. Sydney Marland, Commissioner of the U.S. Office of Education, who proclaimed the educational system was not meeting the needs of its students, including those with handicaps. The federal agency responsible for the education of handicapped students, the Bureau of Education for the Handicapped (now the Office of Special Education), responded quickly to the charge and declared "by 1977, every handicapped child who leaves school will have had career educational training relevant to the job market, meaningful to his career aspiration, and realistic to his fullest potential" (Martin, 1973). BEH made career education one of its major priorities, allocated funds for special projects, conducted a research conference to identify primary career education needs of handicapped students, and supported the efforts of the Council for Exceptional Children (CEC) and others endorsing the development and implementation of this effort for handicapped students.

The Council for Exceptional Children also became strongly supportive of the career education concept for handicapped students in American schools. In addition to sponsoring two national topical conferences on the subject, in 1973 (with the American Vocational Association) and 1979, they have engaged in:

Writing a position paper endorsing the career education concept

Approving a new Division on Career Development (DCD) within CEC

Developing and publishing several curriculum materials, media, monographs, and special issues and articles on the subject

Conducting several developmental career education projects

Offering inservice training assistance to CEC units and others

Providing an information service on materials and resources

Thus, the teacher education association for special educators has strongly supported career education for the handicapped.

Vocational education has also moved ahead rapidly in the 70s, especially since the passage of the Vocational Education Amendments of 1976, which allocate 30 percent of its monies to the handicapped and disadvantaged. A new organization, the National Association of Vocational Education Special Needs Personnel (NAVESNP), evolved to help provide leadership and direction to those in vocational schools and other vocational programs in the educational sector.

As career and vocational education activity has moved forward in American schools, vocational rehabilitation has appeared to have accepted a diminished role. Perhaps the emphasis on meeting the needs of severely handicapped persons and the apparent increased financial endowment of special education due to P.L. 94-142 and vocational education by P.L. 94-482 has effected this posture by the rehabilitation agency. This seeming abrogation of responsibility has been somewhat excruciating to many school personnel because of their lack of expertise in certain vocational areas, most notably counseling, vocational assessment and job placement techniques and resources.

In the past three years, the Rehabilitation Services Administration (RSA) has appeared to be taking a closer look at the role and responsibilities of vocational rehabilitation relative to their engaging in more cooperative/collaborative efforts with special education and vocational education. There have been proclamations to this effect and one or two projects funded to determine how meaningful cooperative rela-

tionships can be put into motion. Texas Tech University was funded to identify ten exemplary programs that can serve as models of special education-vocational rehabilitation collaboration. Now, with RSA and OSE combined under the Office of Special Education and Rehabilitation Services of the new Department of Education, an even greater possibility of cooperative efforts becomes possible.

THE PROBLEMS

The 1970s were characterized by a wave of litigation, legislation, increased funding, special projects, training materials, resource centers, personnel training programs, special conferences and workshops, new organizations and the discovery of new techniques and practices of training the more severely handicapped individual. The Rehabilitation Act of 1973 (P.L. 93-112) and the Education for All Handicapped Children Act (P.L. 94-142) were landmarks of human rights legislation amid many others of great significance. The opportunities for children and adults with handicaps to be prepared for successful living and working has never been better.

Despite all the advances made in the 70s, services to persons with handicaps is being called by many "a national disgrace." The reality of the situation is that a vast number are not receiving the education to which they are entitled under the law and they are not assimilating into society as productive, contributing members of the work force and human race. The White House Conference on Handicapped Individuals of 1977 vividly portrayed the plight of the majority of handicapped Americans. The independent living movement gaining momentum throughout the country and spearheaded by disabled persons themselves is further evidence of the dissatisfaction that abounds in the opinion of these consumers and their advocates who believe they are going to have to do it themselves if they are to make it successfully in today's society. In their estimation, the "rehabilitation paradigm" is completely inadequate for meeting the needs of handicapped individuals and the problem lies with the professional worker and the system, not within the characteristics of the person with a disability.

The Philadelphia *Daily News* (May 5, 1980) reported: "It has been a long year for Robert Wasylenko. The 22-year-old retarded man from the Far Northeast attended Sprunance School until last June, when the public school system's responsibility for him ended. Since he was 19, Wasylenko has been on a waiting list for a planned sheltered workshop; where he would receive physical and occupational therapy as well as

work, maybe on electrical assembly, or packaging. But instead of working this past year, Wasylenko has been at home. Doing nothing."

This is not a rare case—a great many "right to education" graduates will join the ranks of severely handicapped adults "at home, doing nothing" (Laski, 1979). The May 1 issue of *Guidepost*, newsletter of the American Personnel and Guidance Association, depicted the plight of handicapped students in American schools by revealing that thousands of such students are being denied the "appropriate education" to which they are entitled. The publication of the National Center for Law & the Handicapped, *Amicus*, presents case after case of injustices that are being showered upon handicapped people. The reader is encouraged to read the special issue of December 1979, which focuses on vocational rehabilitation and sheltered workshops and the many problems that are inherent in these services.

Although the evidence of inadequate service delivery and preparation of handicapped persons is overwhelming, little really changes. The obvious question is why? Why do the majority of handicapped citizens lead a life of frustration and failure when the potential exists for their success and happiness? The only conceivable answer to me is that the problem rests primarily with the service providers—the bureaucrats, university/college trainers, and service deliverers. For much too long we have placed the blame on lack of money, personnel, and resources as well as the unrealistic demands of the handicapped and their parents. These are not the main problems; the problem is us. We need to change and we need to do it quickly before it is too late.

Dyssegaard makes several important points in her monograph that should be considered by professional workers in special education and rehabilitation. She criticizes special education for not considering long-term goals beyond that of the school years. Her belief, which I share, is that special education's goal should not be separated from the rehabilitation goal. This requires more vocationally oriented programs, greater emphasis on concrete/skill building than on the theoretical, and a more "normal productive involvement" for the student in his/her educational program. Viewing the transition from childhood to young adulthood as the weakest link in the overall rehabilitation program, she recommends four important areas of preparation for young adults: continued education (daily living skills), living situation, occupational preparation and recreation training, all of which most of us in career education most wholeheartedly endorse and practice. She also recommends the rehabilitation program to include the possibilities of continued full-time special education with vocational training.

Other important points made by Dyssegaard are (1) a person with a handicap should not be seen as a representative of a group of handicapped but as an individual with special needs and (2) the best results occur when professionals cooperate. Perhaps these points are all we really need to keep in mind as we attempt to meet the needs of our handicapped citizens. Dyssegaard's monograph reveals that what is being implemented or being attempted in Denmark closely parallels the thinking of most professional workers in the United States.

MAJOR ISSUES

1. *When should the vocational/career preparation of persons with handicaps begin?* There is a large body of mounting evidence that the work personality begins forming at an early age and that vocational/career development should begin during the elementary years and transcend throughout the school period rather than wait until the high school program. If this is true, then purposeful, systematic career development curricula must be implemented to complement traditional academic instruction.

2. *How should vocational/career preparation be provided?* The career education movement provides direction in its conceptualization of four stages of career development: career awareness, career exploration, career preparation, and career placement and continuing education. Career awareness activities and experiences must begin during the elementary years and include a substantial variety of activities and experiential opportunities to learn about the world of productive work activity, paid and unpaid. The involvement of family members and community resources is critical to learning about this area. Career exploration, actual hands-on experiences in career areas of seeming interest, begins at the junior high level and includes initial attempts at vocational assessment and tentative decision-making. Career preparation at the high school level is based on a more rational decision-making process because of the earlier career experiences. Career placement and continuing education assures the student of follow-up assistance and further service as needed over the lifetime. Thus, career education offers a systematic framework in which to view the (re)habilitative effort for students with handicaps.

3. *What should be the roles and responsibilities of special educators and vocational rehabilitation counselors?* Career/vocational preparation in the schools requires special educators to become more knowledgeable and involved in this area, particularly in the career awareness

and exploration stages. However, consultative assistance from vocational rehabilitation counselors is needed. During the career preparation and placement/continuing education stages, vocational rehabilitation counselors need to be much more active and become a significant force in directing the student's career/vocational program with special and vocational educators and other school personnel. If they do not, school personnel, particularly special and vocational educators, will need to receive more extensive formal preparation than they presently get to provide effective vocational services.

4. *Do special education and vocational rehabilitation training programs in colleges and universities need curriculum revision?* Most curricula in these areas are based on concepts of the 50s and 60s and have not responded to the demands of today's needs by both handicapped persons and those that serve them. If substantial positive changes are to be made in the field, we must train personnel properly to carry out the mandates of the day, both legally and ethically. For the most part, this is not happening in the majority of special education and rehabilitation curricula when one inspects their curriculum content. The question is posed as to how can they be made more responsible to the real needs of the field? One way would be for faculty of the two areas to start talking to each other and begin formulating mutually beneficial efforts. Each area has much to offer the other, so that their students can receive the kind of education they need to be more effective with handicapped persons.

Time is running out on professional human service providers, because handicapped citizens are tired of having their hopes built up and then urgently put down. This fact should be impressed on those decision-makers who control the pattern of services to both students and adults with handicaps. We have the capability of being responsive and effective—the question is whether we really want to be.

Brolin, D., Durand, R., Kromer, K., & Muller, P. Post-school adjustment of educable retarded students. *Education and Training of the Mentally Retarded*, 1975.

Chaffin, J., Davison, R., Regan, C., & Spellman, C. Two follow-up studies of former mentally retarded students from the Kansas work study project. *Exceptional Children*, 1971, 37, 733-38.

Kokaska, C.J. The occupational status of the educable mentally retarded: A review of follow-up studies. *Journal of Special Education*, 1968, 2, 4, 369-77.

Laski, F.J. Vocational rehabilitation services for severely handicapped persons: Rights and reality. *Amicus*, 1979, 4, 4-6, 237-45.

Martin, E. Speech presented at National Topical Conference on Career Education for Exceptional Children & Youth, New Orleans, February 12, 1973.

SPECIAL EDUCATION IN DENMARK AND THE UNITED STATES: THE NEED FOR A MODEL PLAN

Helen Jacoby-Blanchard, Ph.D.

Dyssegaard describes the New Danish laws regarding services for handicapped people which include a free education and many other free services that we are not fortunate to have in the United States. In analyzing the present state of the special education system during this transition period, she implies that special education is less than effective in the overall plan of rehabilitation for handicapped persons. She places at least part of the blame on trends which caused regulations and laws to be enacted before the trends were properly evaluated. The present state of special education obviously relates to the old system, where services were secured under laws dealing with specific handicaps. She suggests this as a possible reason for lack of communication between social agencies responsible for planning services. She presents the following conclusions and recommendations:

"Cooperation among professionals is the best way of evaluating the handicapped individual's total needs, and the best way of planning and carrying through a daily and a long-term program of support and development. But since education is the most routinized and standardized part of the daily life of children and young adults, the special education system should be responsible for coordinating and implementing services over the long term. A special education consultant or teacher should be appointed for each family with a handicapped child or young adult. This person acts as the direct line between the handicapped and the entire system of social services."

It would appear unrealistic to place the responsibility of long-range planning with the special education system in its present state as described. If rehabilitation (independent living) is the goal, and special education is the process by which this goal is reached, then a model plan must be prepared with shared responsibility. This is certainly possible under the new laws making the local municipalities responsible for offering all services. The guide for special education prepared for implementation of the new laws will undoubtedly redefine and clarify the role of special education.

Parents and professionals in the United States alike identify and empathize with parents and professionals in Denmark. The problems are parallel. The concept of mainstreaming (a trend which has caused much controversy) was not researched before being put into practice.

Warren (1979) suggests that the concept of special classes for handicapped as well as mainstreaming was not researched before implementation. Fornier-Negroni (1978) applied a framework of policy analysis to the term mainstreaming and concludes: ". . . a need exists in special education to arrive at policy statements based on clearly definable purposes and directions resulting from systematic analysis."

Until the recent reorganization of the Department of Health, Education and Welfare, the agencies responsible for the services to handicapped persons in the United States were separated. Schoolaged handicapped children were and are provided special education services through age twenty-one. Rehabilitation services, with few exceptions, provided and continue to provide after age twenty-one or when special education services terminate. Cooperative programs between special education and rehabilitation developed in the 1960s to provide vocational training for the mentally retarded and vocational counseling for other handicapped schoolaged youth have been, in many parts of the country, discontinued since the passage in 1975 of P.L. 94-142 (guaranteeing the right of all handicapped children to a free and appropriate education). The 1980 reorganization of HEW (creating a separate Department of Education and placing special education and rehabilitation services together) has maximized the possibility of comprehensive long-range planning for handicapped persons. P.L. 95-602 passed in 1978 (providing for comprehensive rehabilitation services to severely and profoundly handicapped persons) adds a new dimension to existing rehabilitation services.

The problems of dealing with trends and fractionated services seem to be common ground for discussion for both Denmark and the United States. The new laws in both countries provide opportunities for realistic change through development of a comprehensive long-range model for rehabilitating or habilitating handicapped persons.

Deloach, C., and Greer B. Adjustment to Severe Disability; A Metamorphosis. McGraw-Hill. In press.

Fornier-Negroni, Y. A Framework for Policy Analysis: An Application for Mainstreaming Handicapped Children. Memphis: Unpublished Dissertation, 1978.

Warren, S. A. What is wrong with mainstreaming? A comment on drastic change. Mental Retardation 1979, 17-6, 301-303.

IMPLEMENTING P.L. 94-142: HOW FAR HAVE WE COME, HOW FAR TO GO?

Patricia Dvonch, Ph.D.

Dyssegaard discusses some of the most urgent problems of special education in relation to a comprehensive rehabilitation program in Denmark. The various studies and experiences discussed in her paper demonstrate what we in the U.S. find to be true: that not only is the "integration or mainstreaming of even severely handicapped children into regular classrooms . . . indeed possible, but also that mainstreaming alone does not always fulfill what is required of a comprehensive rehabilitation program for the individual child."

The purpose of this commentary is to (1) review where the U.S. seems to be in fulfilling the mandates of P.L. 94-142, The Education for All Handicapped Children Act, in relation to rehabilitation services, (2) where we are or what direction we seem to be taking, and (3) what *is* our potential "to develop systems which combine security and opportunity in long-range rehabilitation programs with flexibility and individual arrangements" (Dyssegaard, 1980). The key to P.L. 94-142 is the "individualized education program," IEP, that must be drawn up for each handicapped youngster in consultation with the parents. Mainstreaming—the most controversial aspect of P.L. 94-142—is the provision that handicapped students be put in the "least restrictive environment." Institutionalized youngsters may be transferred to special classes in regular public schools, and children formerly in special classes in public schools may spend part of their "mainstreamed" time in regular classes (*NY Times*, May 13, 1979). Surveys show that mainstreaming has become of paramount concern to public school teachers. Though schools no longer resist, frustration, apprehension, and resentment are reported (Sproles et al., 1978). James Gallegher suggests that, notwithstanding these reactions, the classroom *is* the key. To look at each child individually is the real intent of the law, not to force every handicapped child into a regular classroom (National Public Radio, Washington, DC, June 29, 1980).

P.L. 94-142 (Sections 121A, 13, 121a, 137) also mandates services in which school counselors and rehabilitation counselors assess student needs, evaluate interests and aptitudes, and aid in the formulation of educational and vocational goals. "Since school counselors and rehabilitation counselors provide essential support services, they must

work more closely with each other in the counseling and placement of handicapped children (ASCA/ARCA, March 1980).

The establishment of a vocational rehabilitation component in the education of handicapped children seems essential "to assure that every handicapped child who leaves school has had career education training that is relevant to the job market, meaningful to the individual's career aspirations and realistic to the individual's potential." (Rules & Regulations, Title 45, Public Welfare DHEW Programs for the Education of the Handicapped #121.3, Objectives, 1978).

P.L. 94-142 places the responsibility of providing public education for all special needs children (ages three through twenty-one) on the local public schools. However, state agencies are required to share information, expertise, and services. Thus while eligibility for the school component will be determined through the evaluation process as outlined in the law, rehabilitation and school counselors need to be included in the development of the individual educational plans (IEP). People with physical, mental, or emotional handicaps are generally eligible for rehabilitation services. Upon leaving school, it can be through rehabilitation services, possibly, that transition to another program or employment will be smoother because of the cooperative efforts of the rehabilitation and school counselors (RSCA-ARCA, 1980).

Services to the high-school-age handicapped population should include vocational rehabilitation counseling and preparation for post-high-school programs with the full complement of rehabilitation services. Rehabilitation counselors should be available to provide consultation on the social and vocational aspects of disabilities as well as technical assistance with vocational program planning ideally within the school setting.

The enactment of P.L. 94-142 has led the state Vocational Rehabilitation agencies to reconsider their roles in relationship to the schools, and to some extent they have backed off from continuing the traditionally heavy commitment of expenditures on high school students when similar services are now, according to the law, to be provided by the schools. At the same time the U.S. Office of Education and, more specifically, the Rehabilitation Service Administration are developing guidelines for appropriate collaboration in the future (Sigelman et al., 1979).

Vocational education has been an integral part of rehabilitation planning and programs in a number of State Vocational Rehabilitation programs over the years. Colorado has had such a program for the educationally mentally retarded for more than ten years. Three profes-

sionals have had major responsibility: the classroom teacher, the Vocational Rehabilitation counselor (hired by the educational systems specifically for the program), and the State OVR counselor. This is a variation of similar programs and practices throughout the United States that have been in operation for many years; e.g., New York State has assigned Vocational Rehabilitation counselors to particular schools (plural assignments) as a general rule until recently. There are now plans for an innovative pilot program of collaboration by OVR with the Board of Education to provide Rehabilitation Mobile School units to serve eight high schools in the New York City district (Palevsky, 1980). The State of New Jersey, too, is in the process of "interagency planning" to find the most productive ways for Special Education/Rehabilitation Services to be provided to adolescent consumers (Fleming, 1980).

So-called "generic" counselors as well as school counselors are being advised to "become competent" in a number of areas through pre- or in-service training (Hosie, 1979). The areas suggested include federal and state legislation, rights of the handicapped individual, assessment procedures and the skills necessary to relate these to the special learning strategies of the handicapped, characteristics and impediments of the disabled person, attitudinal bases of teachers and others, and characteristics of the handicapped related to employment skills, training programs and occupational and educational opportunities (Hosie, 1979). These areas of special knowledge and skill are what make up the unique competencies of the profession of rehabilitation counseling.

It thus seems crucial to address the fact that together, school counselors, special education teachers, and rehabilitation counselors can make a profoun d contribution to and impact on the lives of disabled youngsters by pooli g their considerable knowledges and skills in consultative and practicing modalities that will avoid competition and duplication and will directly and immediately have an effect on the implementation of P.L. 94-142. To paraphrase Dyssegaard; to secure the rights of handicapped persons and their families in having available expertise in all necessary areas integrated into the rehabilitation programs designed, wherever that program is offered, is our goal.

ASCA-ARCA Position Statement, 1979, APGA National Convention. Atlanta, Ga 1980.

Burnett, F.E. The comprehensive involvement of the school counselor in career education. *Guidepost*, supplement A&C, February 7, 1980.

DHEW, Office of Education, Bureau of Education for the Handicapped, Rules and Regulations. Title 45-Public Welfare, December 29, 1978.

Fiske, E.B. Educating the Disabled Is Really Something Special, *The New York Times*, Sunday, May 13, 1980.

Fleming, Thomas. Chief of Training, Division of Vocational Rehabilitation New Jersey, personal communication, July, 1980.

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COMPREHENSIVE PROGRAMMING THROUGH LOCAL COMMUNITIES: PUTTING PRINCIPLES INTO ACTION

Rick Heber, Ph.D.

Mental retardation ranks as a major international health, social, and economic problem. Many retarded persons are severely limited in their ability to care for themselves and to engage in productive work. Each year nations are denied several billion dollars of economic output because of the underachievement, underproduction, and/or complete incapability of the mentally retarded. In addition, the untold human anguish and loss of happiness and well being which result from mental retardation blight the future of millions of families throughout the world. Despite extensive research and effective preventive measures, some children and adults in every society will always be handicapped to some degree by mental retardation.

An inclusive array of services must be available if one is to prescribe a treatment plan for a particular retarded individual at any given time. Ideally, these services should be administered by and through instrumentalities which administer to the nonretarded; the family; the professions; the health, education, and rehabilitation agencies. The elements in this service array should be so intimately related to one another, and so accessible, as to be considered a continuum of care.

Birgit Dyssegard presents one such model system, stressing the interface of special education in the overall rehabilitation program for the mentally retarded. The model is based on the author's experiences with the American and Danish delivery systems and on the new Danish law requiring special education to become an integral part of an overall rehabilitation program. The comprehensive system and services described do not presently exist in the United States or Denmark but Dyssegaard provides detailed suggestions for the development of a community-based, service-delivery system beginning with maternal prenatal services and including vocational training programs that are coordinated and begun in special education classes. Throughout this proposed system, special education is not viewed as a goal in itself separately from the goal of rehabilitation. In contrast, special education as well as health and social services are viewed as part of an overall rehabilitation plan that is designed for each mentally retarded individual.

In the United States, comprehensive coordinated service plans for the mentally retarded have been emphasized for decades. Fre-

quently this concept has been labeled continuum of care, implying a service-delivery concept that describes the selection, blending, and use in proper sequence and relationship of the medical, educational, and social services to minimize an individual's disability at every point in his life span. As early as 1962, President Kennedy's Panel on Mental Retardation underscored this principle by defining and describing continuum of care in detail:

> ". . . 'care' is used in its broadest sense and the word 'continuum' underscores the many transitions and liaisons, within and among various services and professions by which the community attempts to secure for the retarded the kind and variety of help and accommodation his needs require. A 'continuum of care' permits fluidity of movement of the individual from one type of service to another while maintaining a sharp focus on his unique requirements. The ongoing process of assuring that an individual receives the services he needs when he needs them and in the amount and variety he requires is the essence of planning and coordination."

Recently in the United States three major federal laws (P.L. 91-517, 1970; P.L. 94-103, 1975; P.L. 95-602) were passed mandating the development of an extensive locally administered and coordinated service delivery system emphasizing a continuum of time. Through these laws (commonly referred to as the Developmental Disabilities Acts), each individual state is mandated to develop a state plan for the provision of services for persons with developmental disabilities, including the mentally retarded. Services are defined as specialized services or special adaptations of generic services directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation and/or rehabilitation of the handicapped individual. This monograph outlines one such model system that a state could employ in developing a comprehensive continuum of prevention as well as habilitation services.

Providing comprehensive programming through local communities is a principle like many others that is easier to articulate than to apply. The design and implementation of inclusive, coordinated lifelong support services for mentally retarded persons and their families remain a basic goal. By eliminating such truisms as "When special education ends, rehabilitation begins" and designing comprehensive rehabilitation programs as the author has in this monograph, future effective and cost-efficient model services interfacing special education and rehabilitation may be designed and implemented.

THE INTERFACE OF SPECIAL EDUCATION AND REHABILITATION SERVICES: RESPONSE AND PRESENTATION

Abstract of a half hour talk given at the conference

Robert A. Stodden, Ph.D.

This paper briefly summarizes and responds to a monograph by Birgit Dyssegaard, and suggests further recommendations for interfacing special education and rehabilitation services for the disabled person. Much of the monograph relates to the delivery of services in Denmark; many of the following comments are concerned with interdisciplinary efforts in the United States.

The author of the monograph describes how Denmark is planning for the delivery of comprehensive services which seem to match many of the mandates of P.L. 94-142 in the United States. It is advocated that the principles of normalization and decentralization be implemented as an approach toward the provision of comprehensive services. Further guidance is offered as to how special education services can be a part of the total delivery of rehabilitation services. Services are recommended from birth through adulthood, to include a wide variety of roles and persons who might meet a variety of client needs. Areas of concern in planning services, such as personnel preparation, parental roles, funding support, and recreational programs are presented for consideration.

The monograph describes many services that Special Education might provide within the rehabilitation process. Most professionals in the fields of special education and rehabilitation agree readily with the need for comprehensive services, as described, but disagree or are unaware of efficient means through which to operationalize these services. Many of the difficulties experienced with the cooperative delivery of special education and rehabilitation services in the United States have been operational in scope, to the extent that services are offered piecemeal and unrelated to the developmental growth of the client. The following is a listing of operational concerns regarding the interdisciplinary implementation of special education and rehabilitation services.

1. It is time to recognize the value of "whole" person developmental services that are interrelated from a growth focus, neces-

sitating interdisciplinary cooperation and support among special education and rehabilitation personnel. The present role needs and turf issues make such cooperation difficult and often non-existent.

2. There is a need to recognize that increasing funding and extending stuffing patterns are not necessarily related to the quality of services contributing to the independent growth and functioning of the client. Present patterns for the allocation of funds encourage discipline isolation and lack of cooperation.

3. When viewing the delivery of services from birth through adulthood, it is necessary to understand the developmental and transitional growth nature of the many necessary program elements in a service delivery and how these elements relate to each other.

4. There is a need to draw further relationships between environmental and occupational needs of the community and the often isolated training and education settings in which clients are placed.

5. It is necessary to increase career development programming as an integrated part of the client's program from birth through adulthood. There is a need for an increased focus upon adult functioning competencies at an early age.

6. The focus of services for disabled persons must center upon increasing the independent functioning of the client, rather than encouragement for the maintenance and dependency producing programs.

7. There is a need for clarification as to the functioning of the team process, as it relates to the total delivery of special education and rehabilitation services.

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Project Year 1979-80

TITLE	AUTHOR
1 Readaptation After Myocardial Infarction	Harald Sanne, M.D. Department of Rehabilitation Medicine 1 Sahlgren's Hospital University of Goteborg Goteborg, Sweden
2 Hospital Based Community Support Services for Recovering Chronic Schizophrenics: The Experience at Lillhagen Hospital, Goteborg, Sweden	S.J. Dencker, M.D. Department II Lillhagen Hospital S-422 03 Hising Backa Sweden
3 Vocational Training for Independent Living	Trevor R. Parmenter, B.A., M.A.C.E. Senior Lecturer in Special Education Macquarie University North Ryde, Australia
4 The Value of Independent Living: Looking at Cost Effectiveness in the U.K. (Issues for Discussion in the U.S.)	Jean Simkins The Economist Intelligence Unit 27 St. James Place London, England
5 Attitudes and Disabled People: Issues for Discussion	Vic Finkelstein, B.A. (Hons), M.A., P.G.C.E., A.B.Ps.S; Lecturer, Post-Experience Course Unit The Open University Milton Keynes, MK7 6AA Great Britain
6 Early Rehabilitation at the Work Place	Aila Jarvikoski Rehabilitation Foundation Helsinki
7 The Role of Special Education in an Overall Rehabilitation Program	Birgit Dyssegaard Head, Department of Special Education County of Copenhagen Denmark

8 Early Detection of Potential Disability in High Risk Infants: A Center for Early Medical and Social Action in France — Roger Salbreux, Institut de Puericulture de Paris, Paris

9 The Use of Volunteers (Especially the Disabled) in an Overall Rehabilitation Program — George Wilson, Royal Association for Disability and Rehabilitation, 25 Mortimer Street, London, England